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DAVID A. FOX

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SELF PERCEPTION IN A HOSPITALIZED ACUTE PSYCHIATRIC POPULATION

David A. Fox, A.B.
Harvard University, 1962

A Thesis Presented to the Faculty of the
Yale University School of Medicine in Partial Fulfillment
of the Requirements for the Degree of Doctor of Medicine

Department of Psychiatry
Yale University School of Medicine
1966

Der Mensch erkennt sich nur im Menschen, nur
Das Leben lehret jedem was er sei

Goethe, Tasso. Act II, Sc. III

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CHAPTER I

INTRODUCTION

Background in Personality and Psychoanalytic Theory

The term "self" has been used in many different contexts and with many different meanings in sociological, psychological, psychiatric, and psychoanalytic writings. A brief historical survey of the usages will be of value both in relating the various conceptualizations of the self cast in different frameworks. This will hopefully enable us to arrive at a precise definition of what we mean by the self, self-perception, and self-esteem and at the same time allow the formulation of a rational construct in the studies to be described below. In the following sections we will be examining many different concepts of the self, as well as related concepts of ego, identity, and personality. In attempting to integrate many of these concepts into a coherent framework and to relate concepts which are not strictly comparable in level of abstraction, it was necessary to do a certain injustice to the theories of some of the authors discussed. On occasion, inferences were drawn when considerations pertinent to our discussion were not made explicit by their proponents. It was felt that these attempts were justified in order to facilitate the presentation of this diverse material.

Social Concepts of the Self

Although William James had discussed the importance of the self, which he described as "all the things which have the power to produce in the stream of consciousness excitement of a certain peculiar sort," the social thinkers Charles Cooley and G.H. Mead were of prime influence in evoking a sustained interest in the concept of the self and its functions. Cooley (1961) noted that the self-feeling (or perception of one's self) is a means whereby we differentiate between ourself and other people. But he proclaims that the relationship is a mutual one and that others are also necessary for the formation of the self. The concept of the self is seen to have three principle elements: the imagination of our appearance to the other; the imagination of his judgment of us; and a core of inner feelings and motives. He states that growth in personality takes place through the appreciation of the reflection of our present self to others.

Mead (1934) is concerned more with the social origins of the self than with its function. For him the self is more a cognitive than an emotional phenomenon. Its importance lies in the relations of an individual to specific others and to the community as a whole. He describes the self as totally dependent on the individual's social milieu for its existence, stating that "The individual possesses a self only in relation to the selves of other members of the social group" (1934, p. 164). Mead describes the acquisition of a "self" by an individual as occurring in the process of communication with another person during which the individual is affected by the attitude of the other towards him. If in his responses to the other he takes into account the attitude of the other (and is thus affected by his own communication), his self has emerged. This process may be conceived

as analogous to "introjection" in psychoanalytic usage. It differs from the latter concept in that it is a process occurring at a later stage in the child's development and occurs with respect to non-parental, as well as parental figures. Mead parallels another aspect of psychoanalytic theory by stating that the self is not completed by this process of exchange with specific individuals but must also incorporate the "attitude of the generalized other," of the community at large. The individual can then respond to his own self in the same way that others respond to it. For Mead, an important characteristic of the self is that it can be an object to itself. But the self is not only the knower and the known; it has internal structure, a division between the "I" and the "me." Basing his argument on the fact that one's actions can never be fully known in advance, he conceptualizes the "I" as the actor, the "process," and the innovator. The "I" is only known by the actions which it has completed, and thus remains permanently behind the current perceptual process. We shall discuss later the relations between this "I" and the psychoanalytic ego. In contrast, Mead describes the "me" as that part of the individual which is known and relatively predictable (structure as opposed to process), even though some of its habits are unconscious. Mead hypothesizes that the self is maintained in the fact of external threat by its attachment to previous successes and known areas of superiority.

Both Cooley and Mead see the self as intimately involved in the social process. It is concluded that the self engages in multiple feedback relations with other "selves" and that both parties establish a set of expectations (for themselves and for the others), reinforce social norms,

and in the process continually refine the experience of "selfhood" and the concept of the self.

Goffman (1959) explores in greater detail the role of the self concept in specific situations. Drawing from the analysis of a wide variety of social encounters, he expresses the view that the self concept not only is modified by the social environment, but also plays a major part in directing overt action. The individual may lie anywhere on the continuum between cynicism and belief in the "self" which is presenting to others in a social situation, but at any position engages in numerous recognized and unrecognized maneuvers to make this "self" credible to others. The individual may shift his position along this belief-in-self continuum during repeated exposures to the situation. We are led to the concept of a multiplicity of social "selves" contributing to an overall self concept. This contribution can be either positive (and additive) or negative, "I am not what I seem." The tendency towards the latter is increased by divergent expectations of behavior from others in current or past social encounters.

We have not arrived at a precise definition of the "self" nor clarified its relationship to other concepts such as the total personality, the ego (and other structural concepts), the identity, or even to the body of the individual. For this we shall have to turn to other thinkers, of whom Harry Stack Sullivan represents a focal point in his integration of psychoanalytic and social conceptualizations.

Psychoanalytic Perspectives

Sullivan (1940, 1953) was dissatisfied with the neglect of interpersonal processes in psychoanalytic formulations of the development of

personality. He agreed with Mead that the self is constructed of reflected appraisals, but also speculated about non-cognitive processes which brought about its formation. He states (1953, p. 165) that the self-system is the "organization of educative experience called into being by the necessity to avoid or minimize incidents of anxiety." Once formed, however, the self-system (seen as primarily dynamic and functional rather than structural) resists change and the intrusion of the external world. The self dynamism then functions to protect the individual against the reappearance of anxiety. In part, this is accomplished by the division of the self into the personifications "good-me," "bad-me," and "not-me," arising with reference to the emotions as well as the perceptions of the other in the interpersonal situation. Small amounts of anxiety within the self-system function as a "signal" protective mechanism against greater anxiety engendered by threatening interpersonal experiences. This function is not without hazard, for the threat of anxiety interferes with attempts to bring the self-system into line with reality. Systematic distortion and perceptual defense prevent a confrontation of the self-system with the "objective" self. If the self-system regulates perceptual functions, how does it differ from Freud's concept of the ego?

Freud (1923) assigns to the ego the role of control over the perceptual apparatus and the integration of mental functioning. However, the ego is described as an entity as well as a process. Earlier (1914, p. 55), he spoke of the relation between the ego and self-esteem. The feeling of self-regard appears as a global measure of the ego; what various components go to make up that measure is irrelevant. Everything we possess or achieve, every remnant of the primitive feeling of omnipotence that experience has corroborated, helps to exalt the self-regard. In Freud's

discussion of narcissism (1923) which he applied to people in general, he states that the ego attempts to obtain for itself possession of libido invested in objects and present itself as a love object to the id. The ego attempts to have itself treated as the equivalent of an external object. This approaches the social psychological formulations of the self discussed above. This conception of a structural mental system (the ego) acting as a type of self is a difficult one. Chein (1944) first suggested a solution to the problems it raises by defining ego motives as "a structured set of interrelated motives centering about the awareness of self." This statement, however, is only a beginning in clarifying the relationship between the ego and the self.

Hartmann (1950) in a very influential paper expanded on this idea, stating "The opposite of object cathexis is not ego cathexis, but the cathexis of one's own person (self-cathexis)." From this argument it follows that libidinal (or aggressive) energy is not focused on the ego alone, but on the id and superego as well. Actually, we mean that such energy is not focused on the conceptual structures, but on their representations in the ego. In order to avoid the confusion associated with lack of distinction between an external object and its internal image, the concept of object representations had been introduced into psychoanalytic writings. In a similar way Hartmann speaks of the self-representations for the "unconscious, preconscious, and conscious representations of the bodily and mental self in the system ego." We must then be in a position to define the self which is thus represented. Hartmann's (1950) statement that the self equals the whole person of an individual, including his body and body parts as well as his psychic organization and its parts, has in general been accepted by those who have continued in this work.

Before going on to consider elaborations and modifications of this schema, we would do well to comment on a few of its implications. The self is seen as the total person, but how close can we come to experiencing this totality? Certainly the individual himself cannot, as many of the representations of self are unconscious. The outside observer in many ways is restricted from a knowledge of this self, and his view of the self is necessarily different (avoiding the question for the moment of which view is "correct"). Kaywin (1959), following the lead of Allport, suggests the use of the term personality to indicate the person as he appears to outsiders. This definition neglects the important anatomic and physiologic components of the person which cannot be subsumed under "personality." For this reason I propose the term "observable self." This term avoids the judgmental bias implied in Kaywin's thesis that "the well analyzed person may be in a better position to form a subjective concept of the self which more closely approximates his... 'objective' self." The objection to the use of the term "objective self" rests with the fact that the self is not subject to direct measures, but must always be assessed through the eyes (and with the biases) of another human being. Chein (1944) clarifies the position of the self "in space" from the point of view of the external observer, by distinguishing the body as the object of perception from the self as the content of that perception.

The use of the terms "observable self" and "self-representations" imply quite correctly that the self is a second order construct. The research to be described below is concerned primarily with the first two terms and their interrelation. An important aspect of this relation is stressed by Jacobson (1965) who refers to Fenichel's separation of two sources of the self image. The first source is the direct awareness of

inner experience--emotions, thoughts, sensations, and functional activity. The second is indirect observation of the self as an object. The external observer has direct access to only the second. He may be aware of the first in some instances, but in general they are available only through their conversion into the second type by the person's indirect self perception.

Developmental Approaches

We are now in a position to consider three important publications by Edith Jacobson (1954, 1959, 1964) which will extend our pursuit of the structural and functional relationships of the self and provide some basic speculations about its intrapsychic origins. Concerning the latter she states (1954, p. 85):

> From the ever-increasing memory traces of pleasurable and unpleasurable experiences and of perceptions with which they become associated, body images as well as images of the love objects emerge which, at first vague and variable, gradually expand and develop into consistent and more or less realistic endopsychic representations of the object world and of our own self.

Jacobson considers that the distinction between self and object is the crucial moment in the establishment of the ego. Bressler (1965) concurs and defines this process as the child's first mental act. This initial self-object differentiation is by no means stable. At first it is easier for the child to distinguish between objects than to separate them from himself. Jacobson (1959) states that transitory fusions between self and object images are normal in children until the age of three.

The further development of the self image derives from two sources: the growing mastery of body control with the beginning predominance of self-initiated activities, and the increasing capacity for identification

with external objects. The first of these is not only related to emerging independence, but also to the establishment of stability in perceptual-motor systems, a necessary prerequisite for a stable self concept. The self concept begins to be based on identification instead of the more primitive modes of incorporation (of parts) and introjection (of characteristics) which have formed its core. Multiple identifications become possible, with the resultant overlapping of self images. During this period projective mechanisms are utilized to expel parts of the self representations that are alien to the ego, or "bad." With the onset of the Oedipal stage a greater toleration appears for these alien parts of the self, especially as self esteem comes to be regulated more and more from within. Schmale (1962) states that at this period the self representation no longer requires constant external gratification for its maintenance. But these changes are related to the development of the superego and require us to briefly discuss some of its relations to the self.

Thus far we have only considered the development of the images of the "real" self, while neglecting the concomitant evolution of the "ideal" self, ego ideal, or superego. Kaywin (1959) recommends in this context that we replace the superego and ego ideal by "superself." Jacobson (1964) proposes that ideal images are laid down even before the complete separation of self and object images. The ego ideal is nourished from partial identifications with idealized aspects of love objects. As the child enters the Oedipal period his growing ego capacity for cognition brings about a sharper separation of "real" and ideal images. This separation occurs because the self image begins to include affect and thought processes as well as ego processes in the integrated form characteristic of the adult self concept.

The formation of the superego involves major shifts in cathexes of the self. The self is now an object for the superego and becomes invested with both the libidinal and aggressive energies which are withdrawn from parental objects. If we substitute ego for self in this statement, we are left with Freud's thesis (1917) about the substiate for the depressive state. The superego is able to partly control the distribution of these cathexes to the self images and thus is established as a major force in internal regulation. The independence of the self esteem from external events increases somewhat after the resolution of the Oedipal conflicts. Not only is the self esteem more stable, but the content of the self representations achieve greater consistency and continuity until the disruptions of puberty and adolescence. During the latency period the child is aided in his self perception by his ability to refer to the values and standards of his peer group, a process already described by Mead.

During the adolescent upheaval many new identifications are formed, which although often transitory, contributed to the self representations. Perhaps even more important are the concerns with the integration of the self representations into a total self concept. Eissler (in Rubinfine, 1958) states that only at puberty does the individual develop the capacity to take himself as a whole object and that only at this time can we then speak of the self as a fourth endopsychic structure. Even if we do not follow this extreme position it is apparent that the new integrations of puberty produce a qualitative change in the experience of the self. Spiegel (1959) devotes considerable attention to the balance of single or small groups of self representations and the total self considered as a

framework for action. He states that the latter is developed from a "pooling" of self representations. In this idea we may perhaps see some resemblance to Mead's concept of taking the attitude of the generalized other and by so doing increase the constancy of the self across multiple social interactions. We are reminded by Goffman (1959) that this constancy is far from realized even in adult life. Spiegel (1959) also states that constancy of self feelings is dependent not only on the stability of the separate self representations and of the total self, but also on the balance of cathexes distributed between the two. He suggests that in adolescence this balance is upset by pressures in the direction of the separate self representative and that this change results in a disturbance of both feelings of personal identity and feelings of the reality of one's own person.

In the adolescent period we are confronted with the problem of the similarities and differences between the concepts of self and of identity. Erikson (1959, p. 102) distinguishes between them as follows:

> The term identity expresses ... a mutual relation in that it connotes both a persistent sameness within one's self (self-sameness) and a persistent sharing of some kind of essential character with others.... The self refers primarily to the intropsychic representation as an inner object.

Another perspective is introduced by Jacobson's (1954, p. 27) remarks on identity formation:

> a process that builds up the ability to preserve the whole psychic organization...as a highly individualized but coherent entity which has direction and continuity at any stage of human development.

She continues that the focus of this identity is on realization of self, fulfillment of potentialities, and role in society. The crucial difference, then, between self perception and feelings of identity is the element of

time perspective which pervades the latter, and its relation to the social community. In utilizing the concept of the self we deliberately consider it separately from the individual's immediate social and interpersonal context. We can then use the concept of the self in describing modes of communication between the individual and his environment. Jacobson from a slightly different point of view speaks of the complementarity of self and object representations and its role in defining the relation between the self and the external world.

Many authors blur the differences which we have tried to discern between self and identity. Lichtenstein (1965) in particular, argues that time dimensionality is an important characteristic of the self. He stresses that the self includes both potential and actualized selves, and that tension exists between them. Potential selves, however, are not necessarily related to the ego ideal. He considers that the self may have another role in addition to providing a frame of reference for the individual. The self may act as an organizing principle influencing the development of psychic structures. We might then consider the self as acting parallel to the ego identity, but primarily acting upon intrapsychic, rather than interpersonal relationships.

Theories Centered on the Self

Working from the perspective of social psychology and phenomenology, Snygg and Combs (1949) have discussed the self in terms which somewhat correspond to the notion of identity. They introduce the term "phenomenal self" in a way analogous to the use of self representations. They do not discuss unconscious aspects of the self image, but emphasize that the conscious and preconscious self concept exerts an important influence on

all behavior. They describe the self concept as built from labels applied to the individual in social interactions and potentially changeable through learning, but in general stable over time. They propose that the self image may be constructed from distorted perceptions of others. In agreement with Angyal (Hall and Lindzey, 1957) they suggest that this process may lead to inappropriate behavior. In contrast to Angyal, they see the self as an integral part of the total psychic structure. They suggest three stages necessary to produce changes in the self concept: 1) external life changes, which may include trauma; 2) refined awareness of the current self concept and of the necessity for changing it; and 3) "acceptance" of change and its integration with other aspects of the self concept. The way the individual then relates to himself and to others can then be understood in terms of changes in his phenomenal field (i.e., life as it appears to him) of which the self is a part.

Rogers (1951) expanded on these ideas and was able to operationalize many of them as we shall see below. He emphasizes the pre-eminence of the self concept in the individual's phenomenal field and states that the self provides a frame of reference with which the individual orients himself to the world. Because of his central importance in studies of the self, we shall quote fairly extensively from his theoretical statements:

> The self-concept or self-structure may be thought of as an organized configuration of perceptions of the self which are *admissible to awareness*. It is composed of such elements as the perceptions of one's characteristics and abilities; the percepts and concepts of the self in relation to others and to the environment; the value qualities which are perceived as associated with experiences and objects; and goals and ideals which are perceived as having positive or negative valence. (1951, p. 136, Italics mine.)

Rogers has not firmly maintained his position of eliminating unconscious elements from the self concept, but there remains a profound difference

between his statements and those of the psychoanalysts. The self construct proposed by the latter group could be said to include Roger's self plus other (unnamed) elements. As expressed by Rogers, the self-structure is a first order construct, directly ascertainable from verbal communications of the individual. There has been no agreement on an experimental model to test directly for parts of the self concept which are not admissible to consciousness.

Rogers (1950) proposes that changes in the self-concept constitute the prime result of psychotherapy. He claims that during therapy there is an increased <u>acceptance</u> of self. This includes the individual seeing himself as a person of worth, basing his standards of behavior on his own experience rather than that of the group, and his perception of internal feelings, motives, and experiences with less distortion. The consequence of these changes is that the self becomes more independent, more competent, and more integrated. These changes are said to be accompanied by behavioral changes, including increased sociability, lessened anxiety, greater emotional stability and control, improvement in adjustment, and increased acceptance of others.

Rogers sees as the motive for changes in therapy the distress felt when a person's behavior is inconsistent with his self concept. Snygg and Combs (1949) as well as Goffman (1959) feel that these differences tend naturally to diminish. Snygg and Combs feel that an inappropriate self concept changes the individual's behavior in a way unfavorable to him. Goffman emphasizes more that changes the self concept tends to follow changes in behavior. It would seem that there must be some persistent obstacle preventing the alignment of self concept and behavior in order to produce motivation for change in therapy. According to Rogers, negative

self feelings (or lowered self esteem) can either occur when the self structure is threatened by external events or is internally inconsistent, whereas positive self feelings occur when the self is firmly organized. Another expression of lowered self esteem would be a high discrepancy between the self concept and the concept of the ideal self. Litwinski (1951), who agrees on the importance of self awareness and self acceptance, feels nevertheless that self esteem depends even more on our gratifications and expectations for gratification from others and from environmental objects and possessions. We shall return to a consideration of the ideas of Rogers and his group in our review of relevant experimental literature.

Other Viewpoints

Another perspective on the self is provided by the writings of Jung and his followers. I shall utilize in this discussion the article by Fordham (1964) which synthesizes many of these ideas. Jung uses the term self in two ways, to indicate the totality of the psyche, including the ego, repressed parts of the ego, and the archetypes; and as the central archetype (Mandala symbol) bringing order into the plurality of archetypes. In its second meaning the self is said to "create the ego in its own image." Perhaps more importantly, the function of the self is to integrate and deintegrate in a cyclic fashion. These cycles allow for growth of the self. The deintegration of the self can take place without disruption of the ego, and ultimately provides for enrichment of the ego and self feeling. In this context the term "ego" is used to indicate the personal component of the psyche as opposed to the archetypal "self." The process of deintegration and reintegration may perhaps be related to the preceding discussion of the rapid changes in self concept and "identity diffusion" during adolescence.

Several other versions of the self will be briefly viewed. Some of these fit into entire theories of personality, whereas others have been expressed as isolated fragments. Cattell (Hall and Lindzey, 1957) proposes a structural self which acts as an organizer, in a somewhat similar manner to the self of Lichtenstein, described above. Parts of the self (traits) may be more or less compatible, but in neurotics certain of these may be dissociated. In all individuals there is a tendency for the real and ideal self to coincide by the modification of both. Menaker (1960) comments on the attempt of patients to project their self image onto others, and to persuade others to see them in the perhaps distorted ways in which they see themselves. His view represents the converse of the thesis of Snygg and Combs. Symonds (Hall and Lindzey, 1957) reminds us that the self may differ in the conscious and unconscious. He notes that self esteem is high when the ego functions well (perhaps the greater integrative power of the ego may then also be applied to the self representations).

Spiegel (1963) mentions that the self implies autonomy and freedom from "robot-like submissiveness." Sexual functioning is considered to play an important part in this image.

In a review of the self concept, Lowe (1961) attempts to distinguish six different "selves" which have bearing on experimental approaches to the study of the self concept: 1) the knowing self which perceives itself; 2) the motivating self, responsible for self-actualizing tendencies (perhaps equivalent to the self proposed by Jung); 3) the self which experiences itself; 4) the self as organizer, concerned with self-consistency; 5) the self as pacifier, reducing internal tension states; 6) the self as the subjective voice of culture (referring here primarily to the concept

of Mead). Lowe attempts to demonstrate that these conceptions of the self are necessarily incompatible and that one is forced to choose between them. We have attempted on the contrary to indicate that if one is careful to define what is meant (structurally or functionally) by the self in each instance that each self is a reflection through a different mirror, and in some ways no more incompatible than the conceptions of the various ego defenses.

The Self in Pathological States

As an introduction to a brief discussion of the self in disturbed states, I would like to use Liang's description of the self that is not present in schizoid or schizophrenic individuals.

> The individual, then, may experience his own being as real, alive, whole; as differentiated from the rest of the world, so that his identity and autonomy are never in question; as a continuum in time; as having an inner consistency, substantiality, genuineness, and worth; as spatially coextensive with the body; and usually as having begun in or around birth and liable to extinction with death. He thus has a firm core of ontological security. (1959, p. 43)

In the schizoid person the self is detached from the body; the body is reacted to as if it were a foreign object. The self retreats from action and interaction with others and becomes less and less a "reality" self and more imbued with fantasy. But a social self may be split off to participate in relations with the outside world. Liang believes that in the course of time the social self becomes a false self which is repudiated and rejected by the ego. Thus such an individual may describe his self (social self) as similar to mother, or perhaps identical with her idea of him. But the sense of identity cannot be maintained unless there is an awareness of some other person who recognizes the "real" self. These concepts are in

some way analogous to Rank's (Laingsroth, 1955) proposals that an imbalance between the given biological self and the acquired social self may lead to severe ego disturbance. Schmale (1962) concurs in the judgment that the disturbance in schizophrenia is related to a disturbance in the relation of the self to the body.

Robert Bak (in Rubinfine, 1958) argues that the core of anxiety in schizophrenia is a threat to the loss of self. He maintains that adequate ego functioning is necessary to preserve both the sense of self and the experience of inner uniqueness. Bizarre behavior and withdrawal are seen in this context as attempts to demarcate the self from the environment. Searles (1955) cites several case studies of schizophrenics who report a fear of merging of self and the external world. A similar situation is reported both by Searles and by Bressler (1965) in which a loss of self is feared because freedom appears impossible under the total control by another (chiefly the mother). This fear of loss is in part preceded by the regressive desire to merge with the mother (or substitute). Jacobson (1964) states that the threat in adolescent schizophrenia is the collapse of the self image. Such a threat might be especially meaningful if we think of the self-system as a structure playing a major part in the organization of the individual's experience.

In states of depersonalization, which often occur early in schizophrenia, similar processes may be at work. Jacobson (1959) conceptualizes a background of conflicting identifications which result in an unstable self concept. Traumatic events may destroy certain of these identifications, leading to a condemnation of the remaining self image. Under the circumstances of failing repression, unacceptable impulses become attached to the already unstable self representations.

The ego then seizes on the opportunity to rid itself of both impulses and self representations and depersonalization results. According to Bressler (1965) part of the ego can then remain intact and observe the worthless, separated image of the self. Lichtenstein (1965) believes that such events may be the result of an initial failure of the ego to synthesize identifications, but that self experiences are sometimes established despite such a failure.

Less has been written about the role of the self in depressive states. Freud (1917) stated that is is the extraordinarily low self esteem of the melancholic patient which separates his reaction from that of normal grief. Freud (1914) also concurs with the general belief that self regard is raised in schizophrenic psychoses. Many psychoanalytically oriented writers believe that the self abuse of depressives represents a diffuse attack on the self (which now includes an introjected love object) by some endopsychic structure generally identified as the superego. The differences between development in normals and depressives may be expressed in the following way. The greater the development of the self perceptual functions by the ego the greater its share in the process of self evaluation and regulation of self esteem. This ego control normally tends to prevent the superego from spreading its criticism of a specific motive to an attack on the entire body of self representations and a resultant depression. The ego is thus able to isolate more successfully agressive cathexis withdrawn from external objects and focused on internalized objects (which have also become representations of the self). The process of spreading aggressive cathexis directed at the self is greatly accentuated by a failure of early complete separation of self and object representations.

Previous Experimental Studies

The vast bulk of studies concerned with the self concept have been reviewed by Wylie (1961). Over 400 references to the literature appear in her bibliography. The majority of these studies were carried out between 1950 and 1960. Since that time the pace of research has not slackened. In view of these realities, we will focus our attention on two areas that bear most meaningfully on our own research, namely studies utilizing the Q-sort, and studies of self perception in psychiatric in-patient populations.

The major impetus for the use and development of the Q-sort as an instrument for research in self perception came from Stephenson (1953) who engaged in major battles with the factor theorists to justify the validity of his technique. According to his original design, the Q-sort consisted of a subject sorting 50-80 statements into 8-12 piles under the influence of a given set of instructions. The number of statements per pile was specified in advance to produce a quasi-normal distribution. For Stephenson, the advantage of the procedure was that the same subject could then arrange the same statements under different sets of instructions, for example, changing from rating items on approval-disapproval dimension to one of like me-unlike me. The two positions of each statement could then be compared. It was then possible to extend the procedure to any number of conditions and any number of persons sorting the statements, the results of which could all be compared by a correlational analysis of the sortings.

The most extensive studies using the Q-sort have been made by Rogers and his group, reported in Rogers and Dymond (1954). The studies reported by Butler and Haigh (two of Rogers' group) (1954), used the correlations between self sorts and ideal sorts made by out-patient

psychotherapy (or counseling) patients before and after therapy. For the self sort, the subject was instructed to sort the items from those that are most like him to those that are least like him; for the ideal sort, the subject sorted the items along the continuum of likeness to the person he would most like to be. The basic assumption underlying this study was derived from Rogers' thesis (discussed above) that discrepancy between self and ideal images is inversely related to self esteem. One hundred items were selected for the sorts from statements made by patients about themselves during therapy. All were reworded into a form applicable to the self of the order, "I am likeable;" "I am worthless," "my hardest battles are with myself." Butler and Haigh found that in a group of college students used as controls the average self-ideal correlation was .58 at first testing and .59 sixty days later. In contrast, their therapy group of 25 patients showed a change in self-ideal correlation from -.01 before therapy to +.34 at the conclusion of treatment. Both the initial and final correlations for the patient group were significantly different from those of the control group, and there was a significant change in the self-ideal correlations over the course of therapy. In this study, therapist ratings of improvement in therapy were not related to changes in the patient's self-ideal correlation.

Rudikoff (1954) undertook a more extensive analysis of changes during outpatient psychotherapy. She correlated self sorts with ideal sorts at the beginning and at the end of therapy. She also correlated sorts both for self and ideal self at the initiation of therapy with sorts for the same concepts at termination. In addition, she introduced a third sort for "average ordinary person" which was performed by the patient before and after therapy. This third sort was correlated with the other

two types of sortings. The results were based on eight cases and showed that the change in self sorting during therapy was significantly greater than the change in average person or ideal. She confirmed Butler and Haigh's result of increased self-ideal correlation after therapy, and in addition demonstrated an increase in the correlation between sorts for self and average person. Although no control group was used in this study, the patients served as their own control. They were tested before and after a 60 day waiting period before the start of therapy. There was no significant change in self-ideal correlation during this period. Although conducted on a small scale, Rudikoff's careful study remains a model of clarity of experimental design and data analysis not often approached by other work in this area.

Phillips _et_ _al_ (1965) have extended Rudikoff's procedure even further, obtaining self and ideal sorts before and after therapy and examining all of the six possible intercorrelations between them. They report on a total of 120 high school and college students in several types of out-patient therapy (directive, non-directive, "eclectic"). Although the data were collected in several different studies, the authors felt that there was enough uniformity in the procedures to warrant combining the data for analysis. The data did not support Rogers' prediction of increased self-ideal correlation after therapy. In general, the correlations between the sorts which they obtained show remarkably little variation (a range of .42 to .63). In all but one group the correlation coefficients between ideal sort pre-therapy and ideal sort post-therapy were higher than those between any other of the sortings which were correlated (e.g. self sort-ideal sort before therapy, or self pre-therapy-self post-therapy). An item analysis of some of their data also revealed

strikingly little change in the rank order of items between various sorts. They conclude that the use of congruence of self and ideal sorts to measure change in therapy is unclear and requires more work. Thus research on change in psychotherapy using the Q-sort method that has been done outside of Rogers' group does not always confirm the basic hypothesis of increased congruence between the sorts for self and ideal self after therapy. The findings of the Rogers group of greater stability of the ideal than the self was confirmed. We are led to speculate about specific effects of Rogerian client-centered counseling applied to a highly selected university population on Q-sort results. Although the studies reported by Phillips et al did include both non-directive counseling and college students, significant differences in the conduct of therapy may have been present nevertheless.

A third method of utilizing the information derived from Q-sorts was proposed by Dymond (1954). She had the 100 Butler and Haigh items rated by six psychologists in terms of their relevance to adjustment. A final set was constructed of 37 items related positively to adjustment, 37 negatively, and 26 unrelated to adjustment. An adjustment score for the self sort was computed by adding the number of positive items placed on the "like me" side of the distribution to the number of negative items placed on the "unlike me" side. She found that adjustment scores were stable over time in control subjects and showed no difference in patients during a wait period of 60 days before the initiation of therapy. There was significant difference between the patient and the control group at all times, and a significant increase in patient adjustment scores during therapy. Change in adjustment score also varied with therapist's rating of success of therapy.

The interpretation of the Dymond score as an adjustment index has not been without serious question. The issue was originally raised by Edwards (1955) who demonstrated that in a normal population the probability of individuals using an item to describe themselves correlated .87 with judgments by the same subjects on the social desirability (whether it is considered desirable or undesirable in others) of the items. Wylie (1961) has reviewed the subsequent work in this area. In general it has been found that high correlations exist between sortings performed along the dimension of adjustment and that of social desirability (.88). High correlations were also found between social desirability and personal well being, social approval, and sickness-health (.89). Thus it seems that at this point in our knowledge any such scale cannot be interpreted in narrowly specific terms, but must be related to the global concepts inseparable from it.

Following the tactics suggested by Stephenson (1953), Frish and Cranston (1956) obtained 14 sorts on patients in therapy from the patient, the therapist, and the therapist's supervisor. The 14 sorts were intercorrelated and factor analyzed. They identified three factors which they labeled "social acceptance," "struggle toward personal acceptance," and "hostility." There was no overall positive or negative change in the self concept during therapy, but a decrease on the first and an increase on the second factor were noted. This type of analysis has also been performed by Rogers (1954a, 1954b) and related in detail to events in the therapy of two patients. Factors of self, ideal, average, and conventional self were extracted from the correlation matrix.

Suinn (1961) used still another mode of Q-sort investigation. He asked a group of high school seniors to perform sorts for self, ideal self,

father, and a male teacher. Father and teacher were also rated by the students for approval or acceptance. It was found that with heightened anxiety, similarity increased between sorts for self and others. Greater self acceptance, on the other hand, increased the distinction between self and others. The results were interpreted in terms of the learning theory constructs of generalization and discrimination (in this case between self and object). Using a different technique, Suinn and Hill (1964) defined the role of anxiety in this context as disrupting the positive correlation between self acceptance and acceptance of other.

We have now surveyed a number of different techniques which have been employed in the study of the self concept with the Q-sort. These include self-ideal (or self-average other) correlations, self-self correlations at two time periods, arrays of self and ideal correlations, adjustment or social desirability scores, multiples sorts for the same person (by himself and by others) with factor analysis, and correlations between self and other real people. Before turning to studies on hospitalized mental patients and adolescents, a few remarks would be in order on the reliability of the Q-sort as a measuring instrument in normal populations. Taylor (1955) reports reliability of .79 after a one week interval (self sorts for 120 college students). Block (1955) reports reliabilities of .80 to .88 for a similar sample over a four week period. Regarding the self-ideal correlation, we have already cited the Rogers and Dymond result showing stability in the control group over varying time periods. A rank order correlation computed from this data by Wylie (1961) is .78.

In contrast to the wealth of material on the self concept in normal and neurotic subjects, research on hospitalized mental patients has been sparse, and in general unsystematic. The bulk of these studies

was reported between 1955 and 1957, and in about half, the Q-sort is the instrument used. We will first consider a group of studies comparing self acceptance or self esteem measures in normals and mixed psychiatric patient populations. Chase (1957) administered Hilden's (#13) set of Q-sorts to hospitalized psychiatric patients and to a group of hospitalized medical and surgical patients. The sets were sorted for self, ideal, and average other. A normative self was constructed by averaging the item placements on the self sorts by half of the non-psychiatric patients, and this hypothetical sorting could be correlated with sortings by individuals. Chase found that correlations between self sorts and ideal, average, and normative self were higher for the non-psychiatric population. There was no significant difference between the ideals described by the sorts of the psychiatric or non-psychiatric patients.

Zuckerman, Baer, and Monashkin (1956) used discrepancy scores on adjective scales between ideal and self, or ideal and other people to obtain acceptance measures of self and others. Their subjects were 60 normals, 30 schizophrenic, and 30 non-schizophrenic psychiatric patients. The patients were tested soon after admission to the hospital. Both patient groups showed less self acceptance and less acceptance of others than their normal group, in concordance with Chase's findings. Within the patient group, however, there was no relation between self acceptance and psychiatrist's rating of adjustment. They noted, surprisingly, that patients with low self-ideal discrepancy showed the most improvement in therapy. A study by Kogan et al (1957) using item means for 25 variables obtained from a Q-sort type procedure, also showed no correlation between observer ratings and patient ratings, although significant correlations were obtained for a normal group. After health-sickness scores (which

correlated .87 with social desirability) were partialed out, significant positive correlations were obtained for both groups. This study indicates the important effects of social desirability on a correlational procedure involving self ratings and observer ratings. These effects may not be predictable in advance.

Achenbach and Zigler (1963) administered two paper and pencil Q-sorts (one using 40 traits, the other 30 statements) to recently admitted state hospital psychiatric patients and to non-psychiatric patients at a general hospital and a veterans hospital. They also rated each patient on social competence, defined by intelligence, education, occupation, employment history, and marital status. Their measure of self acceptance was the amount of disparity between self and ideal sorts. Using a 2X2 analysis of variance they demonstrated that differences in self-ideal disparities were related to social competence, but not to psychiatric versus non-psychiatric type of patient. In both patient groups the Q-sorts showed lower self-ideal disparity in patients with low social competence. To explain this finding, the authors assert that low self-ideal discrepancies may be related to lack of need for achievement and low social guilt. They also cite previous work showing that low social competence is associated with the greater probability of a diagnosis of schizophrenia in psychiatric patients.

The results of the Achenbach-Zigler study contradict the two previously mentioned studies by Chase and Zuckerman _et al_. The patient groups in these studies are difficult to compare, especially in terms of degree of manifest illness at the time of testing. It would certainly be helpful in this regard to have results of self-esteem measures at more than one time period during the patient's hospital course.

Several studies have centered around the differences between self perception of normals, neurotics, and schizophrenics. Friedman (1955) used a Q-sort technique and correlated self and ideal sorts. No significant difference was found in the self-ideal correlations between normals and schizophrenics, although neurotics were significantly lower than both other groups. Hillson and Worchel (1957) achieved a similar result using the Self-Activity Inventory, a series of Likert type scales rated for self, ideal, and other. Discrepancy scores between the ratings are calculated for self-ideal and self-other. The three groups of subjects used in this study were college freshmen, psychiatric out-patients, and schizophrenics hospitalized less than six weeks. All groups were reasonably equal in age, education and socio-economic class. As in the Friedman study, self-ideal discrepancy was greater for neurotics than for normals or hospitalized schizophrenics. This was confirmed by the self score taken alone (a health-sickness or social desirability type measure), which was significantly lower in the neurotic group. Contrary to predictions from Adler's theory that neurotics would have inflated ideals, it was found that ideals for normals and neurotics were equal, and that both were higher than the ideals of the schizophrenics. The neurotics and schizophrenics also had a higher self-other discrepancy score than did the normal group. In the study already discussed, Chase (1957) found no significant differences within his patient group between psychotics, neurotics, and character disorders, although there was a trend for psychotics to have lower self-ideal correlations.

These results certainly call into question any attempt to relate in a linear fashion behavioral or psychiatric disturbance to measures of the self concept such as those which have been described. The research

so far discussed, of course, has by no means exhausted the technical possibilities of the Q-sort as surveyed in the preceding section. Wylie (1961) also suggests, in reviewing several of these studies, that it might be profitable to investigate components of the total self-esteem. She proposed that such research would provide a finer discrimination between different groups of psychiatric patients.

Other studies in this area have involved a variety of methods. Jones (1956) in investigating statistical parameters of unforced sorting, found that schizophrenics sorted with a greater tendency to use the extremes of the dimensions than did neurotics, who in turn produced sorts with greater standard deviations than a normal group. He found, however, that all subjects tended to produce U shaped distributions, rather than the quasi-normal patterns required in a forced sorting. He asks whether such constraints would not tend to reduce the subject's ability to report on self feelings with a minimum of strain (and possible resulting distortion).

A.H. Rogers (1958) compared paranoid schizophrenics and hospital aides in their behavior with respect to two squares of colored glass. The subjects were told that one color was to represent the self and the other the ideal self. The experimenter measured degree of overlap between the two squares, and found that schizophrenics had higher overlap than the controls. Epstein (1955) compared conscious self evaluation of handwriting, voice, name and self with unconscious self evaluation of the first three of these in disguised form in schizophrenics and normals. Differences in conscious ratings were found in handwriting (liked by schizophrenics, disliked by controls) and "self" (liked by controls, disliked by schizophrenics). For measures of unconscious evaluation schizophrenics liked all disguised items more than the normals although no item alone showed a

significant difference. These two studies indicate some of the difficulties in using projective methods in the study of the self concept. Even when the results are relatively clearcut, as in the A.H. Rogers study, the interpretation of findings may be controversial. These two studies would have been more useful if a third group of neurotics or non-schizophrenics had been included in each case. Nevertheless, they do seem to support the general evidence towards lack of self criticism in psychotic subjects.

Three studies will now be discussed which relate to changes in self perception over time or through environmental changes in psychiatric patients. Mahrer and Mason (1965) administered a check list, consisting primarily of names of symptoms to patients in a mixed psychiatric population at three points in time: 1) just prior to admission; 2) four days after admission; 3) some time between four to 16 weeks after admission. They found no significant differences between first and second ratings or second and third ratings; however a comparison of first and third ratings revealed significant decreases in number of symptoms acknowledged. Manese (1965) compared self-ideal and self-expected self correlations in two groups of chronic schizophrenics in partial remission. Hilden's Q-set (#13) was used. The two groups were comparable in terms of past and present psychiatric disability, but one group was currently on in-patient status because of placement problems while the other group was being treated on an out-patient basis. Both the self-ideal and self-expected self correlations were significantly greater ($p < .001$) for the in-patient group. The author related this difference to the effects of stresses of unstructured living on a psychiatrically disabled patient. In conjunction with the Mahrer and Mason study, these results would seem to cast some doubt on the traumatic nature of the experience of hospitalization and its solely deleterious effect on the self image, for certain patient populations.

Laxer (1964a, 1964b) has begun to report on a careful and detailed study of self concept in hospitalized psychiatric patients. His sample consists of 37 paranoid schizophrenics, 37 depressives, and 67 with other diagnoses. His measuring instrument is Osgood's semantic differential, administered for self and ideal at admission and discharge. The following important findings have emerged from this research: 1) depressives show an increase in self-ideal congruence during hospitalization whereas paranoid patients do not; 2) a significant difference in the self images of depressed and paranoid patients is found at admission but not at discharge; 3) a significant correlation between improved self image and behavioral improvement as coded by observers is seen only in depressed patients; 4) there are no significant changes in ideal self for any group; 5) low scores for self sort correlate specifically with depression, and not simply with absence of paranoid projection. Laxer has analyzed these results in the following way. While all groups of patients show raising of mood level between admission and discharge, a self esteem change is seen only in depressives. He then postulates that in depressive patients (who utilize intrapunitive mechanisms of defense) self esteem is more strongly affected by mood shifts than in extrapunitive patients.

Before summarizing the results of this section, I would like to refer briefly to two studies of self concept in adolescents who are not psychiatric patients. (No studies have referred specifically to adolescent patients, although the mean age of patients in Hillson and Worchel's study (1957) was equivalent to that of a group of college freshmen.) Medinnus (1964) using a group of 18 year old boys and girls found that adolescents high in self-acceptance identified more closely with parents. Self-ideal and self-parent discrepancies on two trait lists of adjectives (Bills'

Index of Adjustment and Values, and Osgood's Semantic Differential, both of which are rated on Likert type scales) were used as measures of self-acceptance and identification. Shippee-Blum (1959) measured self-esteem and acceptance of parents in cooperative and rebellious high school students using an adjective check list. She found that rebellious adolescents had more extreme self scores than the cooperators. The rebellious students rated themselves better than their parents, whereas the other group saw themselves as worse than their parents.

Summary and Hypotheses

In summary, studies of the self concept of psychiatric in-patients have reached a moderate degree of consensus despite the bewildering array of methods, measures, indices, and operational definitions employed. In general, psychiatric patients have been found to show greater discrepancy between their descriptions of self and ideal self than normal controls, whether or not the controls were hospitalized at the time of testing. This difference has not always been statistically significant. When psychiatric patients were separated according to diagnostic categories, it was found that in many respects the responses of hospitalized acute schizophrenics resembled those of normals, while depressive patients or unclassified neurotics (who were generally in outpatient psychotherapy) differed significantly (lowered self esteem) from both of the former groups. Depressives were found to change in self esteem between admission and discharge, whereas paranoid patients did not. Attempts to relate self esteem to observer ratings of adjustment in psychiatric patients have produced conflicting results. None of these studies explored in depth the content areas of the self concept.

The study to be described below was undertaken to provide a broad and detailed view of self perception in a group of hospitalized acutely ill psychiatric patients. The study was oriented towards describing self perception soon after admission to the hospital as well as towards considering changes taking place during hospitalization, and to examine specific aspects or components of self perception and their changes. Although a number of hypotheses were formulated, they by no means encompass all of the data collected, since much of the study was by necessity exploratory, particularly in content areas of self perception.

The major hypotheses tested were: 1) the self concept of the patients would be lower in social desirability than the self concept of a comparison group of non-patients; 2) patients would show large discrepancies between concept of self and ideal self; 3) patients would both increase on a social desirability measure and show smaller discrepancies between self and ideal self concepts over a period of hospitalization; and 4) the first three hypotheses would show greater significance for depressive than for non-depressive patients; 5) it was also hypothesized that substantial agreement would exist between the patient and outside observers as to what the patient was like, and that this agreement would increase during the course of the patient's hospitalization.

CHAPTER II

METHODS

Sample

The patients studied in this investigation were admissions to Tompkins 1, the acute psychiatric unit of the Yale-New Haven hospital. As part of a larger project on family attitudes towards the hospitalized psychiatric patient, patients were divided into those from parental homes (living with parents) and those from marital homes (living with spouses). The patients from parental homes were used in this research. Criteria for inclusion in the sample were that patients be less than 25 years of age, unmarried, and have two living parents. All admissions to Topkins 1 between 5/64 - 8/65 who met these criteria were originally included in this study. Because of problems of test scheduling however, several (3) patients were not tested. Another group of six patients left the hospital before completing all materials used in the study, and are not included in the final sample. The cooperation of both parents of patients in the study was obtained in all instances.

The group of patients studied consists of 22 acute psychiatric hospital admissions. There were 14 females and eight males in this group. The average age was 18.4 years and these patients had had an average of 11.4 years of education. The admission and final diagnoses of these patients are given in Appendix A.

In addition, a complete class of 20 students from Southern Connecticut State College was used as a comparison group for some aspects of the study. These students were tested as a group in their classroom and were not remunerated for their cooperation. They were assured of their anonymity in the research project, but were asked to give identifying information, including sex, age, class in college, and father's occupation. The patient and comparison groups were similar in age and amount of education.

The Hospital Setting

Tompkins 1 is the acute psychiatric inpatient ward of the Yale-New Haven Medical Center. Its goals are to foster rapid symptom remission and socialization, and to return patients to the community as quickly as possible (Norton, Detre, and Jarecki, 1963). The average patient stays ten weeks on the ward, and there are from 25 to 31 patients on the ward at one time. The ward fulltime staff consists of the director (Dr. Thomas Detre), two supervising psychiatrists, five psychiatric residents who are usually in their second year of training, a recreation therapist and assistant, three social workers, a psychologist, and a large staff of nurses, aids, and housekeeping staff. The overall staff-patient ratio is 3:1.

Patients are engaged in individual psychotherapy (generally two or three times a week) as well as several types of group therapy. They attend small groups of the five to six patients treated by each resident, large family group meetings (20 to 25 people) and "four-way" groups consisting of their family, the resident, and a social worker. They also attend

"unled" groups in which the patients of one resident meet together without a staff member present. In addition, there are daily meetings concerned with patient government and patient-staff meetings. Most patients on the ward receive drug therapy, but other organic methods of treatment are rarely used. There are no seclusion facilities on the ward.

The ward contains many of the features usually ascribed to a "therapeutic community." Patients are expected to exert considerable self-responsibility and responsibility for others on the ward. Patients who have been on the ward for several weeks are expected to help new arrivals in their adjustment to the ward. Each new patient is "sponsored" for two days by another patient who introduces him into the social and institutional environment. Patients take self responsibility and responsibility for others seriously. In return, staff members usually accept decisions about patients' passes and other privileges made by the patient governing body. Patients are expected to talk openly about their problems in many settings and to help others with self-expression. The ward door is kept unlocked except in ward crises. Patient communication is encouraged by various group activities, statements by the ward staff about the values of social interaction, a "buddy system" for short trips by patients outside the hospital, and even by the sleeping arrangements of four to five beds in most rooms.

Family engagement in therapy on the ward is a requirement. Patients' parents or spouses attend at least two formal meetings on the ward each week. In most instances, there are three or four meetings a week with patients and their families in small or large groups. In addition, one of the social workers sees most family members on a weekly basis. Family

members are encouraged to visit with patients at other times as well, and their involvement in the treatment program is consistently stressed by the ward staff.

Instrument Used: The Q-Sort

A set of Q-sort stems was developed and used in the present research. The items were derived from the Butler and Haigh (1954) set. The original set of 100 items was reduced to 50 in order to eliminate items that would be difficult for younger patients or those with only average intellectual capacity (Butler and Haigh's work was done with a college population). The items were tested on psychiatric patients of average intelligence at Connecticut Valley State Hospital prior to use in this study. The balance of Socially Desirable, Socially Undesirable, and Neutral items in the Butler and Haigh sets was preserved in the new set, respectively 22, 22, and 6 items in each category.

A further modification was necessary in order to administer the Q-sort to a reasonably large number of acutely disturbed psychiatric patients and their families. The set of 50 items was converted into a paper and pencil rating task, shown in Appendix B. This format follows the procedure of Achenbach and Zuckerman (1963). With this method the patient's task was essentially that of performing a Q-sort with an unforced distribution. It has been shown that some information is lost in this procedure (Block, 1956). Pilot work with the forced distribution revealed, however, that it posed marked difficulties for psychiatric patients who were still acutely disturbed at the time of first testing. In the past, the primary disadvantage of using the unforced sort has been the greatly

increased difficulty in comparing the sorts. This problem has been obviated by adequate computer facilities of the 7090-7094 system at the Yale Computer Center. The program for obtaining correlations between the Q-sorts was a modification of the one described by Stillman (1964). A further check on the differences between our method and the forced choice procedure was made by comparing the standard deviation of the Q-sorts done by our subjects with those computed from the quasi-normal sorts used by previous workers. These results indicate that we do not sacrifice significant information for the majority of patients by using our method.

The Q-sort was administered to patients and to their parents between the seventh and fourteenth days of the patient's hospital stay. It was administered separately to each family member. Patients were allowed as much time as they wished to complete the Q-sort and their sheets were checked to verify that they had not omitted any items. They were not informed that the sort would be repeated until they were asked to return approximately seven to eight weeks following the first sort. A few (3) patients who were discharged sooner (after 5-6 weeks) were given the second sort near the time of discharge.

At the time of each sorting the patient performed the sort for five conditions, or images. There were: 1) "Describing Yourself" (self-sort); 2) "Describing Mother;" 3) "Describing Father;" 4) "Describing Yourself As You Would Like To Be;" (ideal sort); 5) Describing Ordinary Average People." Each of the patient's parents performed sorts, for himself, the patient, his spouse, average people and his ideal for the patient. The parents ideal sort for the patient was expressed, "Your Son (Daughter) As You Would Like Him (Her) To Be."

[illegible] in comparing the sorts. [illegible] obviated [illegible] at the Yale Computer Center. The program for [illegible] Q-sorts was a modification of the [illegible] by Stiller (1969). [illegible] further check on the differences between our method [illegible] procedure was made by comparing the [illegible] of the Q-sorts by our subjects with those computed [illegible] previous reports. These results [illegible] significant information for the majority of patients [illegible] method.

The Q-sort was administered to patients and to their parents [illegible] the seventh and fourteenth days of the [illegible]. It was administered separately to each family member. [illegible] such time as they wished to complete the [illegible] checked to verify that they had not omitted [illegible]. They were not informed that the sort would be [illegible] patients who were discharged sooner [illegible]

[illegible]

[illegible] conditions, [illegible]. These were: 1) [illegible] [illegible] [illegible]

Social Desirability

As described above, the balance of Q-sort items in terms of their social desirability (or sickness-health) was maintained in the modification of the Butler and Haigh set of items. Our method of scoring social desirability differs from theirs in the following way. Their scoring procedure consisted of adding together the positive items which fell on the positive ("Like me") side of the patient's distribution and the negative items which fell on the negative ("Unlike me") side of the patient's distribution, and disregarding items which fell in the neutral position. Our method depends on the patient's own mean for each sorting. Since this never coincided exactly with an integer value, all items relevant to social desirability were used in computing the score. In addition, crossed items were subtracted from the patient's score. That is, socially desirable items which were placed on the negative side of the patient's distribution and socially undesirable items placed on the positive side were subtracted from his score. Thus, while the relative values of social desirability remain the same in the two systems, the actual numerical values are not strictly comparable.

Categories

As noted in earlier sections, the purpose of the research was to obtain a differentiated picture of the patient's self perception as well as a global measure of self esteem. This goal was approached by establishing, on a rational basis, a system of ten categories of intrapersonal and interpersonal feelings and behavior, which could be applied to the Q-sorts as well as to the observer ratings of patient behavior to be described below. The category system was in part derived from the work of Leary

(1957) and was modified by the hypotheses to be tested and the types of data to which the categories were to be applied. The categories are expressed as bipolar variables, and each is scored in the manner of the social desirability scores described above. The "positive" poles of the ten categories are as follows:

1) perceived approval by others
2) self-approval
3) absence of psychic and emotional symptoms; mental health
4) sociability, social interest
5) positive feelings towards others; absence of hostility
6) dominance, lack of compliance
7) competence in dealing with internal problems
8) competence in dealing with external problems
9) mood and feeling state; lack of depression
10) emotional expression and acting-out behavior

The first nine of these categories were used in coding the Q-sort items. Category 10 was excluded, as only one item was coded in that category. The 50 items were also coded in terms of these categories by two clinical psychologists, and reliabilities of 70 to 80 per cent were obtained. The remaining differences were discussed and alterations made in the coding of items. Complete disjunction of the categories was not obtained, and about 15 per cent of items were coded in two categories (one item was coded in three categories). As a check on the completeness of the categories in describing relevant feelings and behavior, several hundred items taken from other Q-sort inventories were coded by means of the categories. It was found that this could be done with relative ease and with little ambiguity. The complete set of Q-sort items administered to patients and the category coding of each item is listed in Appendix B.

Observational Variables

Detailed observations of patients on the acute inpatient service are made during their entire hospital stay. These observations are made in the patient's charts on multiple rating scales. Ratings are made weekly on 30 scales by the patient's psychiatrist. The recreation therapist rates the patient weekly on 22 different scales. Three nurses make daily ratings for each patient on 40 scales which in part overlap those rated by the recreation therapist. Certain of these scales were examined individually and related to discrete hypotheses. The majority, however, were grouped together on the basis of the same categories used in coding the Q-sort items. The composite score from several rating scales was used in the correlational analysis.

In addition, ratings were made by the psychiatrist and social worker who worked with the patient and his family in "four-way" therapy. These ratings were made at the time of the administration of the first and second Q-sorts to the patient, and at the time of discharge. The family was rated on degree of communication, mutual support, family "boss", parent with whom the patient identifies, and other variables related to family structure. The improvement of the patient and the family as a whole in therapy was also rated. These rating forms and coding instructions for them are shown in Appendix C.

Background Variables

Background information was obtained from the patient's chart concerning age, family socioeconomic status, education, number of previous hospitalizations, number of previous psychiatrists, and duration of previous psychotherapy. The patient's Information Score on the Wechsler Adult

Intelligence Scale, his feelings about which parent he was closest to and who was the boss in his family, and whether he had ever previously felt the way he did at the time of admission to the ward were obtained from the psychiatrist's initial interview with the patient. Patients were classified as schizophrenic if the diagnoses of schizophrenia (any type). borderline schizophrenia, or borderline psychotic appeared in either the admission or final diagnosis. Patients were classified as depressive if depressive reaction was included in either the initial or final diagnosis. For some aspects of the correlational analysis, patients with diagnosis of "depressive features" were included in the depressive group.

Statistical Procedures

Intercorrelations were obtained for all Q-sorts (self, ideal self, mother, father, and average other) performed by each patient at both testing periods. Correlations were also obtained between all sorts by the patient and by his parents. Scores of total "social desirability" and each of the nine categories were computed for each sort. These scores were correlated with observer ratings for the second and tenth weeks of hospitalization. Changes in patient scores and observer ratings between the two testing periods were intercorrelated. Changes were also correlated with initial values of the scores and ratings.

CHAPTER III

SOCIAL DESIRABILITY

Due to the diversity of the data collected, the results and discussion sections of this study have been separated into four parts. They are divided according to the principal measures described: 1) social desirability scores derived from Q-sorts performed by patients and controls, 2) correlations among Q-sorts performed by the patient, 3) various components of self perception, and 4) correlations between observations about patients by staff members and the previous measures. To some extent these sections can be discussed independently of one another, although frequently evidence from one method supports findings obtained by other methods. Sections 1 and 2 are particularly complementary in this regard, the first describing differences between Q-sorts along one dimension and the second, difference between Q-sorts along (unknown) multi-dimensions.

Throughout the four sections which follow, patients have been divided into diagnostic groupings for some of the data analysis. The patients were dichotomized in two separate ways: first, as schizophrenic versus non-schizophrenic, second, as depressive versus non-depressive. Both distinctions divide the patient sample into two nearly equal parts. It is important to remember that the same group of 22 patients is divided in these two different ways, i.e., each patient appears in both dichotomies.

Results

Initial Social Desirability

The social desirability scores obtained from patients' self ratings on the Q-sort instrument during the second week of hospitalization are presented in table 1. These data are analyzed separately by sex and diagnosis.

Table 1

Initial Social Desirability Scores of Patients

	N	Mean	Standard Deviation	t
Total Group	22	3.09	15.20	
Sex				
Male	8	9.75	14.25	NS
Female	14	0.00	13.21	
Diagnosis				
Schizophrenic	11	4.18	13.64	NS
Non-Schizophrenic	11	2.91	16.04	
Depressive	9	-4.89	10.30	2.24*
Non-Depressive	13	8.62	15.10	

* $p < .05$.

T-tests were used to assess possible differences between the various groups. Only the difference between depressive and non-depressive patients was significant at the $p < .05$ level of significance.

Initial social desirability scores of patients were also analyzed by correlating them with the patient's socioeconomic status, age, and years of education. There was no significant correlation between initial social

desirability and socioeconomic status. In our predominently school-age sample there was a high positive correlation ($r = .86$, $p < .001$) between age and years of education. Both variables correlated negatively with initial social desirability scores, i.e., younger and less educated patients had higher social desirability scores. The correlation of initial social desirability scores with age fell short of the .05 level of significance, but the correlation with years of education was significant at the .05 level.

The analysis of the social desirability for the self concept of the comparison group of Southern Connecticut State College students is presented in table 2.

Table 2

Social Desirability Scores of Comparison Group

	N	Mean	Standard Deviation	t
Total Group	20	26.2	14.8	
Sex				
Male	11	29.3	7.8	NS
Female	9	18.7	17.6	
Age				
19-20	8	20.5	19.0	NS
21-23	12	30.0	9.5	
Socioeconomic Status				
High	6	23.3	17.8	NS
Low	10	29.0	13.4	
Not Reported	4	25.0	12.0	

None of the means of any dichotomized group differed significantly. The variance in social desirability of the female group was significantly greater than the variance of the male group ($p < .01$), and the variance of the younger group was greater than that of the older group ($p < .05$). The patient and non-patient groups were similar in that females had a lower social desirability score than males in both groups. The trends for age, however, were in opposite directions, although neither trend was significant.

A comparison of tables 1 and 2 reveals that the mean social desirability score for the patient group is lower than the score for the controls. This difference is highly significant ($t = 3.62$, 42 *df*, $p < .001$). This finding substantiates the work done with psychiatric outpatients by Dymond (1954), using an item set from which our Q-sort was derived. In fact, the actual scores in Dymond's study, when adjusted for the number of items used and the differences in scoring procedure, are strikingly similar to our results. The adjusted score for patients in her study lies between 2 and 6. In our patients the means score is 3.09. For control groups the scores are 22 - 28 and 26.2, respectively.

Changes in Social Desirability

We next turn to changes in the social desirability of the patient's self concept during the first ten weeks of his hospitalization. These data are presented in table 3.

Table 3

Changes in Social Desirability Scores:
Means of Patients' Self Sorts

	N	1st Sort	2nd Sort	Change	p
Total Group	22	3.09	14.00	+10.91	∠ .01
Sex					
Males	8	9.75	10.75	+ 1.00	NS
Females	14	0.00	15.86	+15.86	∠ .01
Diagnosis					
Schizophrenics	11	4.18	13.09	+ 8.91	NS
NonSchizophrenics	11	2.91	16.04	+13.13	∠ .01
Depressives	9	-4.89	13.78	+18.67	∠ .001
Non-Depressives	13	8.62	14.16	+ 5.54	NS

The increase in social desirability scores was significant for the patient group taken as a whole, as we had predicted. At the time of the second Q-sort, the social desirability scores of the patient group continue to differ significantly (t = 2.50, p ∠ .02) from the scores of the non-patient comparison group, despite the significant increase in the patient scores.

The increase in scores for the patient sub-groups occurred most strikingly for the patients that were lowest initially. These low scorers include the female patients, patients diagnosed as depressive, and patients not diagnosed as schizophrenic. The consequence of these changes was to decrease markedly the differences between sub-groups at the time of second testing.

Other Social Desirability Scores

The patient's social desirability score from his self-sort may also be viewed profitably in the context of the social desirability scores we

derived from his sortings for his ideal self, his parents, and the average person in other Q-sorts. These data are presented in table 4.

Table 4

Social Desirability Scores of Sorts by Patients for Self and Other Images (Mean Scores)

Type of Sort	1st Sort	2nd Sort	Change	p
Self	3.09	14.00	+10.91	$< .01$
Ideal	31.5	39.0	+ 7.5	NS
Average	24.7	25.8	+ 1.1	NS
Parents	20.3	25.6	+ 5.3	NS

The patient views himself as lower in social desirability than his parents, his ideal self, and the average person both at initial and final testings. Social desirability scores for all sorts increase between the two testings. The patient's self concept improves to the greatest extent during hospitalization, followed by his concept of his ideal self. Although the social desirability of the patient's ideal self did not show significant change by t-test, the non-parametric sign test reveals that a significant number of patients increased their scores (15 of the 18 patients who showed some change between first and second Q-sort increased their scores, p = .01). The patient's concept of the average person seems to be quite stable.

The discrepancy between self and ideal self in terms of social desirability diminishes during hospitalization. There is no significant difference between diagnostic groups in the social desirability rating of the ideal self, either at the first or second testing, in contrast to the findings for the self image.

The discrepancy between self and parents or average people also decreases during hospitalization. The patient see himself as consistently less socially desirable than his parents, although his concept of them is less stable than his concept of the average person. Of the 88 times that the patient's self-rating could be compared with the patient's rating of his parents, on only 8 occasions did he see himself as equal or better in social desirability than either of his parents.

We may also use the information from social desirability scores as one method of comparing the way the patient sees himself and the way in which he is seen by others. For this data the "others" are the patient's parents, whose biases must be recognized. In addition, the parents' perception of change in the patient is also affected by the parents' participation in group therapy on the ward. The data in table 5 is none the less of interest.

Table 5

Social Desirability Scores of Sorts Describing the Patient (Mean Scores)

Person Sorting	1st Sort	2nd Sort	Change	p
Patient	3.09	14.0	+10.9	$< .01$
Mother	5.36	11.0	+ 5.4	NS
Father	3.73	8.5	+ 4.8	NS

We note that there is reasonably close correspondence in social desirability scores between the patient's view of himself and the way he is seen by his parents. This correspondence is slightly higher on the first sorting than on the second, primarily due to the fact that the parents see the patient as changing less than the patient sees himself as changing. As we shall find later this fact is confirmed by correlational data. The assumption

underlying our comparisons, that the patient and his parents use approximately the same reference point in rating the patient, is supported by their close agreement in rating the social desirability of the average person. This is seen in Table 6.

Table 6

Social Desirability Scores of Sorts for Average Ordinary Person (Mean Scores)

Person Sorting	1st Sort	2nd Sort	Change	p
Patient	24.7	25.8	+ 1.8	NS
Mother	25.5	24.2	- 1.3	NS
Father	20.2	24.8	+ 4.6	NS

Discussion

The discussion of findings from social desirability scores used as a measure of self perception will center around four major areas: 1) the differences between the patients and a non-patient comparison group; 2) changes in patients during hospitalization; 3) differences among sub-groups of patients; and 4) comparison of changes in perception of self to changes of perception of ideal self or others.

The data indicate that, soon after admission, acute psychiatric patients saw themselves as less socially desirable than a comparison group of college sophomores. As noted earlier, this rating is equivalent to the patient's saying that he is sick or poorly adjusted. The college students do not see themselves in this light. This difference corroborates previous work done by others. The difference in social desirability scores between the patient and non-patient groups remains significant when the patient scores at the time of second testing are compared with scores of the controls. The simplest explanation for this persistent difference is that

indeed the social desirability score for self is a reliable indicator of mental illness, or perhaps an index of social functioning. There is no question that our patients are not as adjusted as normal college sophomores, even after ten weeks of hospitalization. We do not know, of course, what our patients' scores might have been before their acute episode when they were coping more effectively with their environment.

The change in the patients' social desirability scores (Table 3) substantiates our hypothesis that an increase in the patients' self ratings occurs between the second and tenth week of hospitalization. As noted above, previous work has shown that no significant change in social desirability occurs in normal individuals during this interval of time. In repeating the assessment of patients' self perception after a fixed time interval, we controlled the duration of the patient's exposure to the hospital environment. In contrast to previous studies, we are also freed from the restriction that the time of retesting depends upon the individual psychiatrist's definition of "cure" or remission. Our results in this area are therefore not strictly comparable to the findings of studies which have retested patients on completion of therapy. However, since all patients experienced approximately the same interval of time in the hospital, our data provides information on the effects of hospitalization <u>per se</u> and the passage of time during an acute illness on the self perception of acute adolescent psychiatric inpatients. What factors, then, may be relevant to this positive change in their self concept?

There are several factors which might interact to produce this change. One hypothesis is that the patient is sicker at the beginning of hospitalization and improves. Thus the patient's rating of himself might be an accurate reflection of the extent of his psychopathology or

maladjustment, something which is "cured" during hospitalization. This is a reasonable assumption and one for which we have some evidence, in that the psychiatrists and nurses, and to a lesser extent the parents of the patients, saw the patient as sicker at first and improving during the period between sorts. However, there was no significant correlation for individual patients between the improvement noted by others and increases in social desirability of each particular patient's self perception. This aspect of the results will be discussed more fully below.

Another possible explanation of the increase in patients' social desirability scores is that the patient's view of himself was lowered by the impact of hospitalization and by his early experiences in the hospital, and that it gradually recovered towards levels held prior to hospitalization. This is a difficult hypothesis to prove or exclude on the basis of our data. Mahrer and Mason's (1965) finding that there were no differences in their measure of self concept before and immediately after hospitalization provides some evidence against the hypothesis that the patients' self concept is positive until the time of hospitalization and that it suffers a sharp fall upon hospitalization. The evidence from this single study is not, however, conclusive.

Kaplan _et_ _al_ (1964) suggested two factors which do operate to lower the self esteem of the hospitalized mental patient, the social stigma attached to mental illness and the very nature of the process of therapy. Regarding the latter, they speak of the patient's recognition of the need for help as a starting point for therapy, as well as the increased vulnerability of self esteem during either individual therapy or during membership in a therapeutic community. This paper also delineates some of the measures which patients take to defend against their loss of self

esteem. One defensive tactic discussed is the patient's identifying himself as less sick than the other patients. This strategy is particularly relevant to our consideration of change in social desirability scores during hospitalization. Patients at the time of second testing are "old" established members of the ward community and are expected to be of help to newer arrivals. This role may make an important contribution to increasing self esteem.

One of the striking findings of the study was the difference in initial social desirability scores for self between patients diagnosed as depressive reaction and those who were not labeled as such. Although both groups initially saw themselves as significantly "sicker" or less desirable than the normals, the depressive patients were significantly below the other patients. The low initial scores of depressive patients confirm the work of Laxer (1946a). The difference in social desirability scores between the depressive and non-depressive groups was less pronounced when patients diagnosed as having "depressive features" were included in the depressive group. The patients with "depressive features" had higher social desirability scores for self at the initial testing than the patients formally diagnosed as depressive. This finding offers tentative support for the diagnostic criteria used in classifying our patients. We might also see this result as confirmation of Laxer's (1964b) thesis that depressive patients (as a psychodynamic type) react to mood swings with greater changes in self perception than do non-depressives.

The schizophrenic and mixed groups also showed lower social desirability scores than the normals in this study or than normals studied by Dymond (1954). This finding partially conflicts with the reports of previous studies, some of which demonstrated that schizophrenic (or psychotic)

patients did not differ from normals in self acceptance, although neurotic or depressive hospitalized patients did. Among our patients, the total group, the schizophrenic group, and the (mixed) non-depressive group all produced initial social desirability scores which were in the range of the scores of the neurotic outpatients studied by Dymond (1954).

The significant difference between male and female patients in change in social desirability scores (the means can be seen in table 3, $p < .01$) also led us to examine the diagnostic structure of the patient group. The differentiation of the patients into schizophrenics and non-schizophrenics revealed some discrepancies, but not enough to account for the male-female differences. When the patients were divided into depressives and non-depressives, a major source of this difference was elucidated. Namely, the female population contained all but two of the depressed patients. This also indicated that diagnosis is a more important source of variance in the data than is sex. This finding again supports Laxer's (1964a) previous research with a group of state hospital patients. Dymond's (1954) group of outpatients changed in social desirability scores almost to the same extent as our depressive patients.

We might ask what similarities there are between the situations of psychiatric outpatients in once or twice a week therapy, depressive patients in a state hospital, and depressive patients in an acute intensive treatment psychiatric unit that would lead to an increase in the social desirability of their self perception in a relatively brief period of time. These are patients who initially have an abnormally low self image, and therefore have the most room in which to change. However, in our patient group the non-depressed patients also see themselves as far from their ideal self or from the average person in social desirability, allowing

them ample room for change. Another explanation for the rapid changes in social desirability may lie with depressive mechanisms common to all of these patients, rather than being related to mental illness or maladjustment.

We inquired earlier about the relationship between social desirability scores as derived from patient sortings and ratings of psychopathology by nurses and psychiatrists and found that there was no significant correlation. However, change scores are significantly related in that decreases in depression as rated by observers do correlate significantly with increases in social desirability for the total patient group. In fact, initial depression and later decreases in depression (as rated by nurses and psychiatric residents) correlate more highly with increases in social desirability scores than do any other observational or demographic variables investigated. As we shall see below when we discuss the internal structure of the patient's self perception, the changes in patient's self ratings of depression (as derived from a separate score obtained from the Q-sort--which is dealt with later) also correlate more highly with changes in social desirability scores than do changes in any other of the components of self perception.

Two further changes occur between the time of the first and second testings that support the relationship between depression and social desirability of the self perception. These findings became evident in studying differences between the patients diagnosed as depressive and non-depressive. There is a significant difference between the two groups at the time of the first testing both in ratings of depression by observers and in self ratings of social desirability. Differences between the two groups in either rating are no longer present at the second testings. Thus,

in our patient group the social desirability of the self description seems to vary more in relation to the specific dimension of depression than to the general dimension of adjustment or sickness-health.

In table 4 we noted that the patient's description of his ideal self did not increase significantly in social desirability, although a significant number of patients increased their scores during hospitalization. It was anticipated that if our results followed that of earlier studies that there would be no large change in the social desirability of the ideal self. Pilot work of ours however, on a previous sample, had led us to expect some increase in this score. Our patients did tend to show greater change in these scores than did previous patients groups studied. The only study with which we might compare the absolute values of the social desirability scores for ideal self is that of Rudikoff (1954). The range of values within which her group of outpatients would fall (converted as described above for the Dymond data) is 32 to 38, near the scores of our patients.

We might inquire briefly about possible meanings of the social desirability score of the ideal self. It provides a valid point of comparison for the social desirability of the self image. But when we contrast the social desirability scores of the ideal self of one person with another, or of the same person at two different times, we can only relate each score to the standards set by a group of professional people who originally categorized the Q-sort items. We have no basis for assuming that it would be "healthier" to have an image of the ideal self that is high in social desirability, or that it would be more "realistic" for a mental patient to have lower goals than a normal person. Nor is it

certain that a high social desirability score for the ideal self can be related to such concepts as a "strong" or a "demanding" superego. We might more reasonably consider a high score to be a measure of social conformity and a reflection on cultural penetration. Superego "pressure" might more easily be operationalized in terms of the discrepancy between self and ideal self as we will discuss in the next section.

We might agree with the self theorists that changes in the self percept are more important than changes in the ideal self for progress in therapy. There are many forces at work in the patient's environment which would have a greater effect on his self concept than on his notion of how he would like to be ideally. The emphasis within the ward setting is on observable behavior, rather than on statements of intent. The patient is forced to focus constantly on his behavior; his effect on others is communicated to him. He is also asked to perform and observe his own behavior in new and strange situations. In contrast, less emphasis is placed on "shoulds" or "oughts", or on abstract ideals. The expressed values and goals of the ward are limited in scope, and the patient is even reminded that some ward standards of behavior are not tolerated "on the outside".

Another way of conceptualizing the difference between changes in social desirability scores for self and ideal self is that the ideal self represents an intrinsically more stable image. We speak of the stable (and perhaps rigid) superego organization of the individual which is established in childhood, and is thereafter relatively inaccessible to outside influence. This stability might be contrasted with the adolescent's problem of identity diffusion and uncertainty of self image, as elaborated by Jacobson (1964). Our measure of the patient's perception of his ideal self, however, probably does not tap much of the early formed and partially

unconscious superego. Instead, it is more likely to reflect more transitory ego identifications. The adolescent who changes from asceticism to a libertine position, as noted by Anna Freud (1936), also changes aspects of his expressed ideals for himself.

In this context, we might distinguish two types of change in the self, one occurring in "real life" situations and the other in the "as if" conditions of psychotherapy. In the latter case, changes in ideals might be likely to occur because the patients' original goals in therapy are often replaced by new objectives in the course of continued non-directive interaction between patient and therapist. In the former situation changes in the self might tend to be directed with respect to pre-existing (and relatively unchanging) ideal goals for the self, even when new potentialities are discovered in novel situations. The psychiatric ward presents the patient with both of these types of environments for change. We might then see this situation as a cause for change in both images of self and ideal self, with greater change produced in the self image.

The patient's concept of the average person also show little change in social desirability between the two testing periods. This finding provides further support for our assumption that the social desirability scores of Q-sort descriptions have a fair degree of stability over time, unless actual changes in the representations of self or other images take place. We note that the concept of self moves closer to that of the average person. It is interesting to find, as a reflexion of our patients' reality testing, that their description of the "average person" is remarkably close in social desirability to the way that "average people", i.e., our comparison group of college students, describe themselves. Our control group may indeed be similar in education and socio-economic status to the

average people with whom our patients have had contact. The lack of change in the concept of the average person is somewhat surprising in view of the wealth of new interpersonal experience facing our patients between their first and second sortings. Of course, patients may specifically exclude their experiences on the ward from contributing to their concept of "average people".

We found that the patient sees his parents as similar in social desirability to the average person, or slightly lower. In the vast majority of instances, the parent is seen as more socially desirable than the patients. We might consider that although behaviorally, many of our patients would fit into Shippee-Blum's (1959) classification of rebellious adolescents (disruption of schoolwork, conflict with authorities) they did not (see Introduction) see themselves as more socially desirable than their parents, as did those adolescents. This is an example of how correlations relevant to a normal group no longer hold for individuals with a more serious disturbance.

We are now in a position to look at our patients' perceptions of the social desirability of their self images not only in absolute terms (and in comparison with a non-patient group) but in relation to other significant aspects of the phenomenal field; ideal, average people, and parents. The conclusion is unavoidable that patients see themselves as worse or inferior to their concepts of all of these. They are at the bottom of the heap. Between the first and second descriptions of themselves and others, the patients' relative positions improve, although they remain at the bottom of the hierarchy. We also noted that the parents agree with this relative position of the patient. The patient has been given the clear message by his parents or their representatives that his behavior is unacceptable, and as a consequence he is deprived of his liberty and much

of his freedom of action. Although the perception of his position is painful for him to accept, he is rewarded by both staff and the patient community for his admission that he is "sick" at the beginning of his hospitalization. Later on, he is rewarded by the community for saying that he is "better" and for acting in a manner consonant with this statement. These conditions may affect his self perception to a considerable degree. We will discuss below whether his behavior as seen by others does match up to his description of himself as healthier or more socially desirable.

CHAPTER IV

CORRELATIONS OF Q-SORT ITEMS

Results

The following results are derived from the correlations between the 50 items for pairs of Q-sort distributions. From this statistic we obtain an indication of the overall similarity of the two concepts being compared. This comparison can be made within or across time periods and for sortings by the same individual or by different individuals. The results are presented in terms of average z-scores ($\bar{z}$) and average r-scores ($\bar{r}$) derived from them, following the precedure of MacNemar (1957). In all cases, the $\bar{z}$-scores were used in tests of significance. Due to the large number of degrees of freedom in z-scores derived from correlations involving 50 items, small differences between average correlations are significant. For example, comparing two $\bar{z}$-scores for possible differences, each derived from 20 correlations, the .05 level of significance for the difference is .09. For $\bar{z}$-scores derived from ten correlations, the .05 level of significance is .13.

The results described below concern correlations between Q-sorts for self and ideal self performed by the patient group. Correlations between each image over time are also presented. Also described are the correlations of the patients concerning concept of the average person, which are less central to this research.

Intercorrelations of Q-sorts performed by the patient during the second and tenth weeks of his hospitalization provide a second type of global measure of self perception. Correlations were performed not only within each testing, but also between the two testings for all five images rated by the patients. As mentioned above, the correlation used most extensively in previous work is that between self and ideal, assessed at the same point in time. We expected that findings for the self-ideal correlations would be similar to those already discussed for social desirability scores of the self sorting. Results for self-ideal self correlations of the total group and the breakdown by diagnostic groups are presented in table 7.

Table 7

Correlations between Sorts by Patients for Self and for Ideal Self at Two Time Periods

	N	(Self-Ideal Self) 1st Sort		(Self-Ideal Self) 2nd Sort		p
		$\bar{z}$	$\bar{r}$	$\bar{z}$	$\bar{r}$	
Total Group	21	.15	(.15)	.47	(.44)	$< .001$
Diagnosis						
Depressives	9	.00	(.00)	.42	(.40)	$< .001$
Non-Depressives	12	.26	(.25)	.51	(.47)	$< .001$
Schizophrenics	11	.23	(.23)	.44	(.41)	$< .001$
Non-Schizophrenics	10	.07	(.07)	.50	(.46)	$< .001$

Comparing these results with those in Table 3, we find an overall similarity of patern. The correlation between patients' self and ideal self images increased, from the first to the second sort, as did social desirability scores for the self image. In both measures, depressives showed a greater increase than non-depressives, and non-schizophrenics increased more than schizophrenics.

There are, however, two differences between these measures. 1) The magnitude of the self-ideal self correlation coefficients is similar for the two diagnostic breakdowns, whereas the social desirability scores show a greater differentiation between depressives and non-depressives than between schizophrenics and non-schizophrenics. 2) At the second testing, the depressive group does not differ from the schizophrenic group in self-ideal self correlation, although there is a clear difference in social desirability scores. In this context we note the contribution of the five non-schizophrenic, non-depressive patients to these averaged correlations. Their average correlations are $\bar{z} = .65$ ($\bar{r} = .57$), significantly higher than those of the other patients.

Our data correspond well with the results of Butler and Haigh (1954) with psychiatric outpatients. The self-ideal self correlations in their total patient group increased from -.01 to .36, whereas their improved group increased from .02 to .47. The self-ideal self correlations of their control group changed over the same period from .66 to .68. Since the difference between the measures of social desirability and self-ideal self correlations depends largely on the patient's sort for his ideal self, we will now turn to a brief consideration of this image.

We noted above that there was a moderate increase in the social desirability of the patient's ideal self between the first and second sorts. We found, however, a very high correlation ($\bar{r} = .82$) between the two sorts for ideal self by the total patient group, as seen below in table 9. This result may be compared with Rudikoff's data (1954) which showed an $\bar{r} = .79$ for a group of psychiatric out-patients correlating ideal sorts before and after therapy. In our sample, there is no significant difference in this correlation between the different diagnostic

groups, the range of $\bar{r}$ being from .77 to .85. The depressive group showed the lowest stability of the ideal self image ($\bar{r}$ = .77).

With this information at our disposal we are now in a position to inquire further into the relationship between the patient's self concept and his picture of his ideal self over time. To clarify the changes in both concepts, we present the data in table 8, on the crossed correlations between time periods, that is first self with second ideal self and second self with first ideal self.

Table 8

Correlations between Sorts by Patients for Self and for Ideal Self Across Time Periods

	N	Self (1st Sort)-Ideal (2nd Sort)		Self (2nd Sort)-Ideal (1st Sort)	
		$\bar{z}$	$\bar{r}$	$\bar{z}$	$\bar{r}$
Total Group	21	.11	(.11)	.32	(.31)
Diagnosis					
Depressives	9	-.06	(-.06)	.14	(.14)
Non-Depressives	12	.21	(.21)	.45	(.42)
Schizophrenics	11	.13	(.13)	.37	(.35)
Non-Schizophrenics	10	.03	(.03)	.26	(.25)

We note that in all cases, the correlations in the second column of Table 8 are greater than those in the first column, in line with previous evidence that change in the self image rather than in the ideal self image is responsible for the increased self-ideal self correlation at the second testing, compared with the first. That is, the self image on the second sorting moves more in the direction of the initial ideal self than the second ideal self moves in the direction of the initial self image. The

comparison of correlations of self (1st sort) - ideal self (1st sort) and self (1st sort) - ideal self (2nd sort) shows that the former are slightly higher for each group, even though none of the differences are significant. From this finding we may infer that the patient does not change the image of his ideal self in the direction of his initial self perception, but that there is a slight tendency for the ideal self to move away from the initial self image.

Perhaps the most important comparison that can be derived from tables 7 and 8 is between the correlations of self (1st sort) - ideal self (1st sort) and self (2nd sort) - ideal self (1st sort). The latter correlations are significantly higher for all patient groups than the former, indicating that the patient sees himself as progressing towards his initial ideal as well as towards the ideal self which he perceives later in hospitalization.

A comparison of the correlations of self (2nd sort) - ideal self (1st sort) with self (2nd sort) - ideal self (2nd sort) reveals that the concept of the ideal self moves towards the self as it is perceived later during the course of the patient's hospitalization. That is, the concept of the ideal self moves towards the more socially desirable or "better adjusted" concept of the self at the second sort, while at the same time moving slightly away from the initial self image. On closer inspection of tables 7 and 8, however, we find that this shift in the concept of the ideal self takes place primarily in the depressive (and non-schizophrenic) patients. The differences between these correlations for the non-depressive and schizophrenic groups of patients are not significant. Since the ideal self of depressive and non-depressive groups increases to about the same extent in social desirability scores, this is evidence of a greater

"lateral" shift in the ideal self for the depressive group.[1] This lateral shift in the depressive group is in accord with the slightly lower correlations of ideal self (1st sort) with ideal self (2nd sort) in depressive patients, as seen in table 9, which presents the correlations between first and second sortings for patients' concept of ideal self and average person.

Table 9

Correlations over Time Between Sorts by Patients for Average Person and for Ideal Self

	N	Average 1st Sort-Average 2nd Sort		Ideal 1st Sort-Ideal 2nd Sort	
		$\bar{z}$	$\bar{r}$	$\bar{z}$	$\bar{r}$
Total Group	21	.79	(.66)	1.16	(.82)
Diagnosis					
Depressive	9	.95	(.74)	1.02	(.77)
Non-Depressive	12	.67	(.59)	1.27	(.85)
Schizophrenic	11	.59	(.53)	1.11	(.80)
Non-Schizophrenic	10	1.02	(.77)	1.21	(.84)

The overall correlation between patients' sorts for the average person (1st sort) - average person (2nd sort) is $\bar{r} = .66$. The patient's concept of the average person is less stable than his concept of ideal self, despite the greater constancy of the social desirability scores for the average person sort. Schizophrenic patients are significantly lower on

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[1] We use the term "lateral shift" to mean a content change along an axis orthogonal to social desirability. A large lateral shift is equivalent to a large change in the sorting of items which occurs in such a way that there results no net positive or negative change in social desirability score.

the average person (1st sort) - average person (2nd sort) correlation than non-schizophrenic or depressed patients respectively.

Having found that patients see themselves as closer to their own ideal at the time of the second Q-sort than at the initial Q-sort, we might then examine how they see themselves in relation to their concept of the average person. On the basis of the social desirability data we might expect an increase in the correlation between self and average person to be greater than the increase in self-ideal self correlation between sortings since the social desirability score for the average person does not move upward (and thus away from the score for the self) as does the social desirability score for the ideal self. These data are presented in Table 10.

Table 10

Correlations by Patients between Sort for Self and Sort for Average Person at Two Time Periods

	N	1st Sort (Self-Average)		2nd Sort (Self-Average)	
		$\bar{z}$	$\bar{r}$	$\bar{z}$	$\bar{r}$
Total Group	21	.15	(.15)	.38	(.36)
Diagnosis					
Depressive	9	-.04	(-.04)	.27	(.26)
Non-Depressive	12	.29	(.28)	.46	(.43)
Schizophrenic	11	.23	(.23)	.30	(.29)
Non-Schizophrenic	10	.07	(.07)	.46	(.43)

The initial correlations for all groups correspond very closely with their initial self-ideal self correlations in Table 7. The depressive and non-schizophrenic patients see themselves as furthest from their concept of

the average person. At the second sort, however, the patient sees himself as slightly closer to the concept of his ideal self than to his concept of the average person. This result may imply a greater differentiation from others relative to his own self system. This effect occurs despite the increase in correlation between ideal self and average person from $\bar{r} = .56$ at the first testing to $\bar{r} = .71$ at the second testing. The patient does not discriminate better between his concepts of ideal self and the average person after ten weeks of hospitalization. We again find, as we did in the self-ideal self correlations that, at the second sort, the non-depressive, non-schizophrenic patients have a significantly higher correlation between self-average person than other patients; their $\bar{z}$ is .65 ($\bar{r} = .57$). Patients not only see themselves as closer to the average person but also as closer to their own parents at the time of the second sort compared with the first testing. The Wilcoxin sign test is 17 closer to 5 further from their parents, $p \angle .02$.

We now turn to the correlations between the patients' sort for self the first time and the patients' sort for self the second time. We have divided the total group in a number of different ways for the analysis presented in Table 11.

Table 11

Correlations by Patients Between Sort for Self at Initial Testing and Sort for Self at Final Testing

		N	Self (1st Sort)-Self (2nd Sort)	
			$\bar{z}$	$\bar{r}$
Total Group		22	.52	(.48)
Sex				
	Males	8	.41	(.39)
	Females	14	.58	(.53)
Diagnosis				
(1)	Depressive	9	.47	(.44)
	Non-Depressive	13	.55	(.50)
(2)	Schizophrenic	11	.47	(.44)
	Non-Schizophrenic	11	.56	(.51)
(3)	Schizophrenic, excluding Borderline	8	.33	(.32)
	Non-Schizophrenic, including Borderline	14	.62	(.55)
(4)	Borderline	3	.85	(.69)
	Non-Schizophrenic, Non-Depressed	5	.61	(.54)

The self (1st sort) - self (2nd sort) correlation of $\bar{r} = .48$ for the entire patient group is good evidence that our patients change considerably in their self concept during eight weeks of hospitalization. This result is similar to that in Rudikoff's (1954) group of eight psychiatric out-patients in therapy, in whom the self (1st sort) - self

(2nd sort) $\bar{r} = .51$. The average correlations are significantly lower than the retest reliabilities of .79 and .88 cited earlier for a normal college sample. When the group is divided by diagnosis, the depressive patients change in their self concept more than the non-depressive patients, but the schizophrenic patients also change more than the non-schizophrenics. The explanation for this result lies with the patients who are labeled with neither diagnosis. The self concept of these patients appears to change relatively little.

The surprising aspect of these data is the extremely high correlation for the borderline patients between self (1st sort) and self (2nd sort). The average correlations of self (1st sort) - self (2nd sort) are equal for the schizophrenic and depressive groups. However, if the borderline patients are excluded from the schizophrenic group, the correlations for the schizophrenic patients are considerably lower than those for the depressive group. These results are interesting for the following reason. We know that in terms of social desirability the depressive patients change more than twice as much as the schizophrenic patients. By means of this correlational data we then have evidence for a "lateral" shift (i.e., orthogonal to social desirability) in the self concept of the schizophrenic patients which is as great as or possibly larger than the change for the depressive and non-schizophrenic patients. As we will discuss below, this shift may imply a substantial modification in the organization of the self concept of schizophrenic patients during hospitalization.

The relationship between self sorts for patients and control group students was examined by means of correlations. Self sorts at the first testing were intercorrelated for ten patients selected randomly from the

sample. The average z-score for these correlations was .07 ($\bar{r} = .07$). The corresponding statistics for ten students were $\bar{z} = .32$, $\bar{r} = .31$. The difference between these two average correlations was significant at $p < .001$. The average scores for the correlation of each of the ten students with each of the ten patients were $\bar{z} = .03$, $\bar{r} = .03$. Patients thus describe themselves as neither more nor less similar to each other than to a group of normals. The normal students share a greater similarity in self perception than do the patients. The only two correlations significant at the .05 level between initial self sorts for patients (out of 45 correlations computed) were between two female schizophrenics, and between two male schizophrenics.

Although we do not have data on correlations between self-sorts over time for our group of college students, we do have this data for the parents of the patients. In comparing each patient's self (1st sort) - self (2nd sort) correlation with the average of his parents' self (1st sort) - self (2nd sort) correlations for themselves, we find that the correlation is higher for the parents 16 of 20 times. This results is significant by the Wilcoxson sign test (MacNemar, 1957) at the .05 level, and indicates that the patient's self concept is less stable than his parents' self concept during the first ten weeks of the patient's hospitalization. (Or patients see themselves as changing more).

One further set of findings emerges from the correlation of Q-sorts. Although these results bear on the relation of self perception to perception by others and thus fit more properly into section 4, they are considered here for ease of data comparison. We find that the parents of the patients are not as impressed as the patients with changes occurring in the patients during hospitalization. The correlations between the parents' sorts for the

patient as they see him at the second and tenth weeks of hospitalization are presented in table 12.

Table 12

Correlations Between Parents Sorts for Patient at Initial Testing and Parents Sorts for Patient at Final Testing

	N	Patient (1st Sort)-Patient (2nd Sort)	
		$\bar{z}$	$\bar{r}$
Total Parent Group	40	.66	(.56)
Parent Group in terms of Patient's Diagnosis			
Depressive	18	.67	(.56)
Non-Depressive	22	.66	(.56)
Schizophrenic	18	.59	(.53)
Non-Schizophrenic	22	.72	(.62)

In comparing these results with those in Table 11, we find that the patient sees himself as changing more (lower self-self correlation) than the parents see him as changing. This difference is significant at the .05 level for the total group and for the sub-groups which were examined. Depressive and non-depressive patients are seen by their parents as changing to the same extent, but schizophrenic patients are seen by their parents as changing significantly more ($p \angle .01$) than non-schizophrenic patients.

Discussion

The addition of correlational data to the results of the social desirability scores for the Q-sorts provides a much broader base from which to ascribe meaning to our results on self perception. By the use of the correlational data we are able to better comprehend where the patient's perception of self stands in relation to his view of aspects of his total

world. We find, for example, from the correlational data that the patient sees himself as quite different from others (sort for average person). Coupling this information with the data on social desirability we are able to attach a meaningful "number" to the patient's self concept along one dimension which can be compared with the "number" for the patient's concept of the average person along the same dimension. The correlational data informs us of changes or differences between concepts which may not be subsumed under social desirability, and may even be unrelated to any of the a priori categories which we will assess later in order to ascertain specific components of the perception of self and others.

One clear demonstration of the interdependency of the two methods is found in the results on the concept of the ideal self. We find from the social desirability data that a significant number of patients increase the positive valuation of the ideal self between testing periods. Despite this increase, there is a high correlation between the patient's ideal self at the first and second testings. We can infer from these results that despite the increased social desirability scores there is little change in the overall structure of the ideal self. This supposition is strengthened by comparing these results with those for the concept of the self. We find that even though the change in social desirability between the two testings is only slightly greater (11 versus 8.5) for the self concept than for the ideal self, that the average correlation between self (1st sort) and self (2nd sort) is significantly and substantially lower than the correlation between ideal self (1st sort) and ideal self (2nd sort), ($\bar{r} = .48$ versus $\bar{r} = .82$). This comparison allows us to conclude that in contrast to the ideal self the concept of the self undergoes a thorough reorganization during the course of the patient's hospitalization.

These ideas gain further support from a consideration of diagnostic groupings within the patient sample. We find that depressives, compared with non-depressive patients, exhibit during hospitalization a significantly greater increase in the social desirability of the self and in the self-ideal self correlation. The depressive patients change more in the concept of the ideal self as measured by correlational data (though not in terms of social desirability). All of these shifts would be expected from the premise that changes in the superego or ego ideal and the establishment of a new balance between superego and ego would be important in the treatment of depression. The initial low levels in the first two of the measures mentioned above point to a superego condemnation of the self which is widespread and diffuse, but which remits to a considerable extent during hospitalization. Such findings for the depressive patients fit well into the psychoanalytic theory of depression (Fenichel, 1945; Grinker, 1961) and are congruent with previous research. Other writers have postulated that there is a lowering of superego "demands" during recovery from depression. As discussed above this is not operationally equivalent to an expectation that the social desirability score of the ideal self would be lowered. The latter statement would be closer to a theoretical position that depressives suffer from exalted expectations for themselves. This prediction was not confirmed by our social desirability data.

In contrast to the depressives, the schizophrenic patients have relatively little change in the social desirability of the self concept, but a relatively great change in the self image by correlational measures. The schizophrenics also show little change in the ideal self or in the self-ideal self correlation. These findings indicate less change in schizophrenic

patients of the superego and more structural change within the ego (as perceiver) and the self (as the object of perception). On the basis of this evidence we might tentatively agree with the formulation that greater change occurs in the ego of schizophrenic patients as compared with that of depressive patients on the basis of a primary disturbance of ego or of self in schizophrenics. Given the fact that both schizophrenic and depressive patients are improving (that is to say, acceptable in the community after hospitalization, but not before), it is reassuring to find that change in each group occurs in the areas in which it would be predicted by many theories. Although in both schizophrenics and depressives the self image changes more than the concept of the ideal self, the changes in the self image are relatively important for the schizophrenics than in the depressives and changes in the ideal self more prominent in the depressives than in the schizophrenics. The high self (1st sort) - self (2nd sort) correlations in the borderline patients are not easily explicable. In this discussion we must not lose sight of the finding that the depressive patients increased the social desirability scores of their self image to a much greater extent than any other patient group.

Ego changes in the schizophrenic patients can also be inferred from the greater change in their perception of the external world than non-schizophrenic patients. Schizophrenics have a lower correlation than non-schizophrenics over time between their descriptions of the average person. This change in the schizophrenic's perception of his human environment is complementary to Searles' (1960) description of the schizophrenic's changes in the perception of his non-human environment. Even though there is a relatively large change for the schizophrenic patients in sorts for both self and average people, the self-average person correlation remains

essentially unchanged, implying that both concepts are moving parallel to one another. In the schizophrenic (and non-depressive) patients there was a significantly greater change during hospitalization for the concept of the average person than for the ideal self. There was no significant difference between the two changes for the depressive patients. This difference between the patient groups is another example of the importance of perceptual changes in the schizophrenic patients as contrasted with somewhat greater changes in value orientation in the depressive patients.

One factor which must be taken into account is whether or not the data indicating that schizophrenic patients change more in perception of self and others than non-schizophrenic patients is a consequence of the greater original disorganization of the schizophrenic patients. In other words, do schizophrenics respond to the Q-sort in a random fashion at the first testing, and are changes between testings due to more accurate responses the second time? It is difficult to answer such a question for our type of data, and indeed, this may be one factor contributing to our results. The high correlations between first and second sorts for ideal self (and relatively high correlations for the average person) in the schizophrenic patients is at least an index of their initial ability to perform the Q-sort task in a meaningful way. The marked contrast between the changes in the self sorts of the schizophrenics and the stability of the other sortings suggests that the change in the self sort may indeed be relatively specific (a reflection of an actual change in the self concept) rather than only the result of a diffuse perceptual reorganization. We also find that the correlation between sorts for self image in the same patient is very much higher than the average correlation among patients' self images on the first sort, implying non-randomness of the first

self-sort. Interestingly enough, however, when the borderline patients are excluded from the schizophrenic group, the correlations between self (1st sort) and self (2nd sort) for the schizophrenic patients are no higher than the average random intercorrelation among self sorts for the control group, demonstrating the extent of these changes in self perception. This suggests that perhaps some combination of general and specific perceptual changes in these patients provides an extreme change in perception of self (and in its expression).

As discussed above, the increase in correlation between self and ideal self for sub-groups follows the overall pattern of the increase in social desirability scores for the self image during hospitalization. This increased congruence of self and ideal self has been shown by other correlational data to be due primarily to a movement in the concept of the self in the direction of the ideal self. We have noted above the evidence that this change is due more to a decrease in depression or in "intrapunitive behavior" than to a decrease in maladjustment or overall psychopathology. Further evidence for this contention is the fact that the depressive patients are not seen by the psychiatric residents as improving more than the others on an overall basis, even though the depressives increase their self-ideal self correlation significantly more than other patients. One factor which might contribute to the increase in the self-ideal self correlation for the total patient group is that the hospital environment encourages new behaviors, possibly allowing patients to perform competently in areas of previously untried potentialities.

We have discussed the fact that even though the social desirability of the patient's ideal self increases during hospitalization it does not necessarily become less realistic as a goal. We have evidence that the ideal

self at the second sort is actually more realistic (or more attainable) for the individual patient. We observed that the correlation between the patient's concepts of self (2nd sort) and ideal self (2nd sort) is greater than the correlation between self (2nd sort) and ideal self (1st sort), despite the fact that of the two the discrepancy in social desirability scores is greater between self (2nd sort) and ideal self (2nd sort). The effect of these two tendencies is to produce an image of the ideal self on the second sort which is more acceptable than the concept of the self, but which resembles the self in structure (perhaps in strong points and weaknesses). This new goal might be the result of experience in the hospital directed towards the formulation of more realistic goals for the individual patient, a type of reality testing. We might also conceptualize these findings as evidence that even though there is an elevation in the social desirability of the ideal self, there is no concomitent increase in intrapunitive superego pressure, as evidenced by the increase in self-ideal correlation and in the increased social desirability score for the self image. Finally, we might also conclude that our patients are not chasing after a forever vanishing "rainbow"; that they are making progress in their own estimation towards their evolving goals.

We noted that the patients experienced more change (lower correlation) in their self concept than did groups of normals previously studied or did the patients' parents in sorting for themselves. In our discussion of social desirability scores we identified some of the factors which may contribute to such a change. Lessening of depression was considered of prime importance for increasing social desirability scores. We will now alter our focus to consider factors more strictly relevant to change in self concept, rather than to improvement in self rating or self

esteem. We might first ask whether the change in self concept is the result of the remission of an acute illness, or whether it represents a more basic personality change. This question cannot be answered from our present data and could probably only be satisfactorily answered by long term follow up data. The only study which has dealt with follow up data for correlations between self sorts (Rudikoff, 1954) indicated that in almost half of her patients in outpatient psychotherapy, changes as great as those occurring during therapy took place between the end of therapy and follow up six months later. We have already discussed the contention that the changes in self perception of patients are due to the impact of hospitalization at the time of the first Q-sort.

A comparison of Tables 11 and 12 reveals that patients see themselves as changing more than their parents see them as changing. Inevitably the question arises, "Who is correct?" Is the patient deluding himself about the changes that are taking place, or are outside observers (and especially parents) resistant to perceiving changes in familiar objects or just less familiar with the changes that occur? The question of "who is correct" is not a meaningful one in terms of the quantification possible with our current methods. It is possible to examine agreement between patient and observer on direction of change (as with social desirability scores), but it is not logical to decide on an a priori basis which of the two is correct. Another possibility is to determine the extent of agreement between multiple observers and to compare this agreement with the concordance between patient and the observers (see below, section 4). Even this technique, however, does not really bridge the difference in perspective between patient and observer in such a way as to make appropriate the establishment of one viewpoint as the true picture and judging the "accuracy" of the other with respect to it.

There is a general agreement between patients and their parents about which groups of patients change the most during hospitalization. One explanation for both this agreement and for the fact that patients see themselves as changing to a greater extent than parents see them as changing, is that changes in the patient's internal feelings occur more quickly than changes in his overt behavior. More than two time points would be required to test this hypotheses. This view is held by many writers on the process of psychotherapy, who speak of the continued difficulty for patients to translate insight into action.

The patient's perception of the future also contributes to current self perception. Information obtained through interviews with patients not included in this sample indicates that patients on admission see themselves as relatively static or possibly slowly declining in their capacities, whereas after ten weeks in the hospital they see themselves not only as changed, but as continuing to change in the future. The self perceived at the second testing is thus more likely to be influenced by anticipation of future changes and therefore by the patient's concept of his ideal self.

We can also conceptualize the findings of greater change perceived by patients than by their parents by again thinking of the self as both the object of perception and a strong influence on the perceptual apparatus. In contrast to the amount of change seen by an outside observer, the individual perceiving himself would then multiply the observed change by the change in the way in which he perceives. This interaction may perhaps best be illustrated by the finding that patients are perceived by both themselves and their parents as changing more than the parents, but on the other hand patients see both themselves and their parents as changing more than the parents see them as changing.

CHAPTER V

COMPONENTS OF SELF PERCEPTION

Results

We have described the self perceptions of the acute hospitalized psychiatric patient by means of the global measures of social desirability and correlations between self sorts and sorts for other images. Our next task is to examine some of the components which constitute this total picture of self perception, and to differentiate our patient group from controls in terms of these components of self concept. These results are presented in Tables 13-15.

Table 13

Scores on Self-Evaluative Categories for Patients and Controls

Persons Sorting	Other's Approval		Self Approval		Psychological Health	
	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
Patients (N=22)						
1st Sort	1.36	1.32	1.41	6.55	-0.32	2.53
2nd Sort	1.63	1.67	4.63^1	6.03	1.24	2.86
Controls (N=20)	2.60^2	0.80^3	8.70	3.51^3	2.90^2	1.48^3
(Possible Range)	± 3		± 14		± 4	

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1. Significant difference in means ($p < .05$) for first and second sorts on this variable.
2. Significant differences in means ($p < .05$) between patients' second sorts and controls' sorts for these variables.
3. Significant differences in variance ($p < .01$) for patients' averaged sorts and controls' sorts on all three variables.

The first three categories relate closely to the concept of total social desirability as defined above. Of the three, only category 2, self approval, increases significantly between first and second sorts ($t = 2.37$, $p < .05$). Category 3 (psychological health-maturity) falls just short of significance ($t = 1.90$). All three differ significantly from the comparison student group at the first sorting, whereas categories 1 and 3 differ significantly on both sortings. The variance of the patients is significantly greater ($p < .01$) than the controls for all three categories.

The next three categories (categories 4-6) are concerned with interpersonal modes.

Table 14

Scores on Interpersonal Categories for Patients and Controls

	Categories					
	Sociability		Positive Feelings Towards Others		Dominance	
Persons Sorting	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
Patients (N=22)						
1st Sort	-1.18	1.99	0.41	2.06	0.55	1.53
2nd Sort	-0.36[1]	2.71	0.91	2.29	0.55	1.26
Controls (N=20)	1.90[2]	2.57	2.00[3]	0.78[4]	0.51	1.25
(Possible Range	± 5		± 4		± 2	

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1. Second sort significantly different ($p < .05$) from first sort, (means).
2. Control sort significantly different ($p < .001$) from patients' second sort, (means).
3. Control sort significantly different ($p < .05$) from patients' second sort, (means).
4. Control sort significantly different ($p < .001$) from average of patients' sorts (variances).

Category 4 (sociability) is the only one of these three categories to increase significantly ($t = 3.95$, $p < .001$) between the first and second

testings. Category 6 (dominance) does not differ significantly between any of the groups, but categories 4 (sociability) and 5 (positive feelings towards others) differentiate the patient from the control group both at first and second sortings. ($p < .001$ and $p < .05$) respectively). Only for category 5 is their a significant difference in variance between the patients and the control group ($p < .001$).

The last three categories concern competence and emotional tone.

Table 15

Scores on Competence and Mood Categories for Patients and Control

Categories

	External Competence		Internal Competence		Absence of Depression	
Persons Sorting	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
Patients (N=22)						
1st Sort	2.14	4.74	0.45	4.31	-1.41	4.95
2nd Sort	3.82[1]	4.30	1.55	4.57	1.73[1]	4.72
Controls (N=20)	4.80	4.09	3.40	4.82	4.40[2]	4.82
(Possible Range)	± 9		± 10		± 9	

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1. Second sort means significantly different from first sort means ($p < .05$).
2. Control mean significantly different from patients' second sort mean ($p < .05$).

Categories 7 (external competence) and 9 (absence of depression) increased significantly ($p < .05$) during the patients' hospitalization. Category 9 was significantly different from the control group both at first and second sortings, while categories 7 and 8 (internal competence) differed from the control group only at the initial sorting ($p = .01$, $t = 2.68$, for both). There are no significant differences in variance between the groups.

In summary, categories 2, 4, 7, and 9 increased significantly between the patients' first and second sortings. All categories except 6 differed significantly between patients and controls on the first sorting, and categories 1, 3, 4, 5, and 9 also differentiated between patients and controls on the second patient sorting. In all categories except category 6, the patients' second sortings were higher than the first sortings and the controls higher than the patients' second sorting. There were no significant differences in variance between the patients' first and second sortings, but the variability in the control group's scores was significantly lower in categories 1, 2, 3, and 5.

We next must consider the extent to which these category scores are independent of the total social desirability in our patient group and therefore to what extent they can provide additional information. Table 16 shows the correlations between the categories and the total social desirability before and after correction for part-whole correlations (correcting for the contribution of the category to the total social desirability score).

Table 16

Correlations for Patients between Category Scores and Total Social Desirability Scores

Category	Number of Items	Uncorrected Correlations[1]			Corrected Correlations		
		1st Sort	2nd Sort	Change[2]	1st Sort	2nd Sort	Change
		r	r	r	r	r	r
1	3	.60	.66	.62	.53**	.54**	.54**
2	14	.71	.82	.60	.39	.56*	.28
3	4	.55	.82	.76	.37	.69**	.58**
4	5	.50	.56	.35	.36	.39	.23
5	4	.35	.53	.47	.31	.38	.36
6	2	.09	-.22	-.16	.05	-.25	-.20
7	9	.67	.85	.81	.49*	.72***	.73***
8	10	.74	.84	.76	.57**	.73***	.52*
9	9	.78	.85	.82	.59**	.70***	.68***

N=22

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1. Significance reported only for corrected correlations.
2. Change in this Table refers to correlations of change in category score with change in social desirability score from first to second sortings.

* $p < .05$ ** $p < .01$ *** $p < .001$

We note that the uncorrected correlation coefficients are quite high and are compatible with a fair degree of internal cohesion of the social desirability scale. When we turn to the corrected correlations, we note that five of the nine categories are not correlated with the remainder of the social desirability items at the .05 level on the first sort. On the second sort this is true of only three of the nine categories. All of the categories, again with the exception of category 6, increase their correlation with total social desirability between the first and second testing. Further information may be derived from these data about the nature of the social desirability score by examining the pattern of its corrected correlation with the categories. Categories 8 and 9 (internal competence, absence of depression) are most relevant in defining social desirability on the first sort, while for the second sort, categories 3 and 7 (psychological health, external competence) are important in addition to categories 8 and 9. Category 6 (dominance) which is unrelated to social desirability on the first sort becomes negatively related (not significantly) to it on the second sort. Changes in categories 7, 9, and 3 are most closely related to changes in the total social desirability.

We next turn to a consideration of how the category scores relate to diagnosis and background variables. Variables not previously discussed in relation to total social desirability scores will also be examined. These results were obtained by correlating background variables with social desirability scores and category scores. In contrast to the previously described correlations between Q-sorts, the N for these correlations is equal to the number of patients, and a correlation coefficient must be greater than .41 to reach the .05 level of significance.

The only significant difference related to sex appeared for category 4 (2nd sort), where male patients saw themselves as more sociable than females ($p \angle .05$). We noted previously that younger (and less educated) patients saw themselves as more socially desirable on the first sort than the other patients. These patients saw themselves as higher on category 3, (psychological health and maturity) on the first sort. Correlations between category 3 and age and between category 3 and education were -.64 and -.69 respectively ($p \angle .01$ for both). There was a positive correlation between age and increase on category 3 during hospitalization ($r = .39$) which fell just short of the .05 level of significance. This finding may in part be related to the low initial scores of the older patients on category 3. There was an almost significant negative correlation ($r = -.41$) between years of education and absence of depression (category 9) at the time of the first sort. There were no significant correlations between the category scores and socio-economic status, although on the first sort, category 1 (approval by others) almost reached the .05 level, $r = .41$.

The estimate of the patient's intelligence from the information scale of the Wechsler Adult Intelligence Scale was correlated to the social desirability and category scores. Of these, only category 5 (positive feelings towards others) correlated significantly (in a negative direction) with intelligence ($r = -.72$, $p \angle .001$) on the second sort. The increase in category 5 between 1st sort and 2nd sort also related significantly, in a negative direction, to intelligence ($r = -.46$, $p \angle .05$). Two other category scores approached significance in the correlation with intelligence, category 5 (1st sort, $r = -.38$) ($.05 \angle p \angle .10$) and category 9 (2nd sort, $r = -.40$), ($.05 \angle p \angle .10$).

We found previously (using t tests) that social desirability scores did not differentiate between schizophrenics and non-schizophrenics at at either time period. Category 1 (approval by others) is scored higher by schizophrenics than non-schizophrenics on the first sort ($r = .56$, $p < .01$). The correlation remains significant when schizophrenics are contrasted with depressive patients ($r = .49$, $p < .05$). The schizophrenic patients increased their scores on category 1 less than the non-schizophrenics ($r = .38$ ($.05 < p < .10$)), probably because of their higher initial scores. These findings are perhaps more comprehensible if we express them in the reverse fashion, that depressed patients see themselves as less liked and approved by others on admission, but change more in this feeling than schizophrenics.

As expected, depressive patients see themselves as more depressed (seen in category 9) at the time of admission than the other patients ($r = -.42$, $p < .05$). They also see themselves as decreasing in depression somewhat more than other patients ($r = .30$).

We also examined the patients' previous psychiatric experience and related number of previous hospitalizations, number of previous psychiatrists, and amount of time spend in psychotherapy. Neither total social desirability nor any of the category scores related significantly to number of previous hospitalizations. Patients who have seen more psychiatrists have less positive feelings towards others (category 5: $r = -.41$, 1st Q sort; $r = -.47$, $p < .05$, 2nd sort). These patients also show less increase in category 1 (perceived approval by others: $r = -.45$, $p < .05$) and less dominance (category 6) on the second sort ($r = -.41$). Patients who have spent more time in psychotherapy see others as more aproving (category 1: 1st sort, $r = .39$).

Discussion

We have noted that all of the category scores, except 6 (dominance) are significantly lower on the first sort for our patients than for the control group. This finding is not altogether surprising since each of the categories (uncorrected) except for 5 and 6 correlate with total social desirability ($p < .01$) on the first sort, and the difference between our control group and the patients in social desirability is significant at the .001 level. Nevertheless, we may conclude from these data that psychiatric patients differ from non-patients in a number of specific areas of self perception as well as in global measures of self esteem. Some comments on the relative positions of the category scores with respect to the controls are relevant. In relation to the percentage of total possible score, categories 3 (psychological health), 4 (sociability) and 9 (absence of depression) show the greatest differences between the patients and the control group.

The position of category 3 is in some ways the most understandable, and fits in with our ideas about what psychiatric patients are like. Scores on category 3 are composed of the items "I really am disturbed," "I am confused," (both negative), and "I feel emotionally mature," and "I understand myself" (both positive). Agreement with the first two of these statements and disagreement with the latter two would be expected of observers rating psychiatric patients soon after their hospitalization. On the other hand, it is somewhat surprising that a group of predominantly psychotic patients would say this about themselves, or so we have been led to believe by previous studies, some of which have led us to believe that psychiatric patients have little insight as to the extent of their pathology. There are certain differences in our patient group which might

lead to this finding. First, there are no patients diagnosed as overtly paranoid in the group, in contrast to most other studies of hospitalized patients. Second, they are for the most part psychologically educated (having seen an average of 1.7 psychiatrists before admission and having spent, on the average, between six months and a year in psychotherapy). Finally, these characteristics of psychological ill-health are part of the definition of the new patient, on our ward as in most inpatient psychiatric settings. If we agree with the social psychologists on the importance of reflected appraisals in self perception, it is understandable that the patient would tend to accept these judgments made about him by others. Furthermore, patients on the ward are rewarded for making these statements about themselves in the early weeks of their hospitalization.

The fact that category 9 also shows one of the greatest discrepancies between patients' first sorts and controls is also not astonishing, since the majority of our patients are labeled as depressive or having depressive features. This category is composed of statements directly related to depression and other statements, indirectly related, with explicit positive or negative emotional tone. Although we noted that depressive patients have lower scores on category 9 than non-depressive patients, the non-depressive patients in our sample were also more depressed at the beginning of hospitalization than they were two months later. This finding was also noted by Laxer (1964b). In contrast to our discussion about patients' perception of their psychological health, we are less surprised to find that patients admit to their depressive feelings, even though a certain amount of denial of depression might be expected in non-depressive patients.

We did not expect to find that category 4 (sociability) would be one of the categories to show the greatest disparity between patients' first sorts and controls, although we did expect that it would change a good deal while the patient was on the ward. There are several factors which might enter into an initial low score. First, our patients may actually have led more socially isolated lives than the control group. This is somewhat difficult to quantify; however, many of our group of adolescent patients were described by their parents as less socially active than normal adolescents. Second, especially in our schizophrenic and borderline patients, there may be a feeling of greater distance from the social interactions in which the patient does participate, thus generating an experience of aloofness or isolation. That is, the patient may outwardly participate in social interchanges without feeling that he is really involved in them. In this context we might refer to the distinction made by Liang (1954) between real self and social self, and the splitting of them which occurs in schizoid personalities. We can only speculate where on the continuum between these sometimes contradictory selves lies the self that the patient describes while performing our paper and pencil Q-sort. The fact that the patient describes himself relatively low on category 4 may be some evidence that his descriptions fit more closely with his "innermost feelings" than with the self which he tries to project as his image to others. After a week of experience in this ward setting, the patient has probably learned the value of presenting himself to others as willing to engage in social interaction. The patient's self-portrayal by the Q-sort does not reflect this external behavior. Another contributing factor to the patient's low view of his sociability might be the contrast of his own previous experience to the intense social

activity of the ward setting, and his possible feelings of newness to and or exclusion from this network. To satisfy ourselves on this point, it would be necessary to have the patient perform a Q-sort during the hour before hospitalization. We have already discussed, in connection with the total social desirability measure, our concerns about this problem.

Our expectation that category 7 (competence in handling external problems) would be included in those which more strongly differentiate between controls and patients on admission was not upheld. Despite the fact that the patients had failed to maintain themselves in a setting outside the hospital, their feelings of lack of control are not increased out of proportion to the difference in total social desirability score between patients and controls. In fact the t-test between patients and controls for this category was less significant than the t-test for total social desirability. Perhaps the greater feelings of security as a result of hospitalization influenced patients' feelings about their current ability to cope with the world in the direction of greater feelings of control.

We turn now to changes in patients' category scores between the second and tenth weeks of hospitalization. We found that there were significant increases in categories 2, 4, 7, and 9, with category 3 falling just short of significance, even though it is greatest in terms of percentage change. We note that there is a similarity between these categories and those discussed in the previous section (3, 9 and 4). In order to investigate this similarity, the categories were ranked in terms of discrepancy between patients and controls at each time period and by change between patient sortings. The categories were first corrected

for number of items. We found that the categories furthest away from the scores of the control group improved the most (rank order correlation, rho, = .78). Despite this change the rank order of the categories (by discrepancies from controls) was preserved between the two testings (rho_{12} = .91). One possible interpretation of these data is that the effect of hospitalization on self perception is to shore up the weak points, while causing a more modest increase in those areas that are already fairly close to "normal". Other evidence pertinent to this hypothesis is the fact that all categories (except 6) increase their correlation with total social desirability and with each other between testings. Although this fact may in part be a statistical consequence of the generalized increase in positive scores, it is tempting to view it as evidence of increased congruence or homogeneity of the self image. Of course, we are viewing such an "integration" only from one limited viewpoint, that of social desirability, and increased differentiation within the self concept may be occurring along other dimensions. We can assume that this change takes place on the basis of intra-individual shifts rather than from greater uniformity among the patient group. Evidence for this assumption can be found in the fact that there is not a consistent trend towards decreased variance in the category scores between the first and second sortings. We may consider, then, that during the initial two months of hospitalization an initially fragmented self image becomes somewhat more unified, and that parts of the self image based on conflicting identifications may be brought more into alignment.

In the above discussion of the low initial positions of categories 3 (psychological health) and 9 (absence of depression), we implied the bases for expected change in these variables during the patient's

hospitalization. That is, those influences which contribute to the patient's low score on category 3 initially (social definition of the patient role, and ward expectations) also operate to increase this score as the patient nears discharge. Goffman (1959) comments that the self is constructed from not only the perceptions of others, but also from their expectations. Just as the initial period of hospitalization is made easier for the patient who admits being "sick" or disturbed, the patient is also rewarded by the community for later presenting himself as increasingly "healthy", in accordance with its expectations about treatment and cure. These factors are presumably less important for the change in category 9, in which the items are more concerned with emotional reactions than with abstract judgments about the self. Emotional states such as depression, while subject to denial or misperception, are more immediate and less dependent on the social context or consensual definitions.

We have no firm explanation for the extremely high negative correlations between category 3 scores and age or years of education. It is true that older patients are also seen by the psychiatrist as somewhat worse in terms of overall evaluation ($r = -.24$), but this only explains a small part of the correlation. Older and more educated patients, however, may be more sensitive to the social implications of being a mental patient and more concerned about their status in the outside community.

The changes in categories 4 (sociability) and 7 (competence for external problems) may be regarded in a similar way to categories 3 and 9. The difference is that the patient is expected to do more than "talk" about changes, but actually to engage in a large amount of social interaction and to exercise increasing control over his environment. Social interaction, particularly talking about problems with other patients, is

defined as therapeutic and valuable, and the patient is openly pushed to engage in social interchange. (Patients are seen as slightly more socially active by both nurses and recreation therapist at the time of the second sort, although neither change is significant.) In regard to category 7 we discussed the fact that the trauma of hospitalization did not seem to greatly affect the patients' feelings of competence. On the ward the patient learns by both precept and example that a certain degree of competence is required before discharge will be considered. The patient does acquire greater mastery of external problems as a result of this pressure, possibly greater mastery than existed before the beginning of his overt psychiatric disorder. We might contrast this stress on external mastery with the relatively little emphasis placed on control of internal problems (category 8). The patient in this particular inpatient setting is told that he is to expect difficulty in handling internal struggles, and is expressly told that he is being given medication to help him in this control. He is expected to rely on medication in addition to his own resources. For similar reasons there is no significant change in category 5 (positive vs. negative feelings towards others). In contrast to the emphasis on social interaction, there are no explicit expectations about positive feelings towards others, although strong declarations of hostility are discouraged. There may, in fact, be some subtle expectations that hostile feelings are acceptable, since more intelligent patients and those who have spent more time in psychotherapy see themselves as more hostile, especially at the time of the second sort. The finding that patients with more psychological sophistication have more negative feelings towards others may be due in part to the greater facility with which these patients are able to express hostility, but it is not entirely a difference in

externalization of negative feelings, as these patients with greater intelligence also see themselves as more depressed than other patients at the time of second testing.

The other category score which changed significantly during the patients' hospitalization was category 2 (self approval). This category is composed primarily of evaluative statements about the self (e.g. "I have an attractive personality (positive); "I am worthless" (negative)) and is more value oriented than the other categories. We had expected on the basis of the work of Dymond (1954) that this category would be the "essence" of what we labeled as "social desirability" and would correlate very highly with it. The fact that this did not happen has caused us to change our ideas about the meaning of the term we label "total social desirability score". The initial social desirability score correlates most highly with categories 8 (competence in handling internal problems) and 9 (lack of depression). These correlations may be interpreted as reflections of the importance of our patients' psychopathology on their self perception; depression and loss of intrapsychic regulation (impending or overt psychosis) each occur in a majority of our patients. We have already discussed the reasons why categories 3 (psychological health), 7 (external competence) and 9 would be important in defining changes in the total social desirability score of our patients. We might conclude that self approval is an important part of social desirability (as defined by the Dymond study) in a hospitalized and seriously disturbed patient group, but that in contrast to its putative importance in a neurotic outpatient population, it is overshadowed by other aspects of self perception in our sample. We are aided in our efforts to define the position of category 2 (self approval) by noting that it correlates extremely highly with our depression category (the highest of all the intercorrelations

between categories on the second sort, second highest on the first sort, disregarding one category which is artificially elevated). This high correlation should not be surprising if we consider that superego condemnation of the self (and feelings of inadequacy) are integral components of the depressive syndrome; depression and condemnation of self move uniformly, as indicated by our data on self-ideal self correlations. We have data from our patient group in support of this contention, in that a low initial score in category 2 correlates more highly with diagnosis of depression than any of the other categories except 9. Moreover, increase in category 2 score tends to occur more in depressive than in non-depressive patients, although in this case it does not differentiate between the two group appreciably better than several other category scores.

Two categories which did not change significantly between first and second testing, 6 (dominance) and 1 (perceived approval by others), remain to be discussed. As we have seen, category 6 does not relate to total social desirability and does not differentiate our patient group from non-patients. We may conclude from this finding that our patients are not made either more or less compliant by their illness or by the experience of hospitalization, or at least do not see themselves as being so. Category 1 in some ways is similar to category 5 (positive feelings towards others) in that there is little change in the patients' scores between the first and second sorts, and in both categories patients' scores are significantly different from the scores of the control group at the second testing. We might first interpret these facts as a reflection of a realistic situation, that psychiatric patients are less successful than normals in the entire gamut of interpersonal relationships, and thus see themselves as lower in

acceptance by others, positive feelings towards others, and also sociability (category 4). In regarding the changes in these three categories we might pursue this argument with the supposition that although hospitalization on this particular service is capable of changing the patient's valence towards social interaction, it is somewhat less successful in altering the emotions generated in such interaction or in making the patient feel acceptable to others.

We can analyze the importance of category 1 further in view of the fact that our schizophrenic group scores significantly higher on this category than non-schizophrenic patients. By itself, it is difficult to interpret this finding other than to note that our schizophrenic patients are apparently not very paranoid, confirming the absence of this description from the clinical diagnosis. We find, however, that the schizophrenic patients also see themselves as considerably lower than the others on category 5 (positive feelings towards others, $r = -.29$), implying an externalization of hostility and perhaps something akin to narcissism. The correlations on these two categories for depressive patients are slightly lower and in the opposite direction. We might infer conversely that depressive patients are more intrapunitive and tend to idealize external objects. When we examine the changes in scores on category 1 for both groups we find evidence to support the assumption that both processes are operating; the average score for the depressives increases by .91, while the average score for the schizophrenics decreases by .56. Neither of these changes is significant, however. The association between category 1 scores and number of psychiatrists or time spent in psychotherapy, may be a reflection of the fact that both of these historical variables are significantly greater for the schizophrenic group than for non-schizophrenics.

In summary, three areas of self perception seem to be of great importance in both distinguishing between patients and controls at the first testing, and in reflecting the overall improvement in the patients' self esteem. These areas are psychological health, sociability, and absence of depression (categories 3, 4, and 9). As would be expected, depressive patients show a greater increase in scores on category 9 than non-depressives during hospitalization. Increases in category 3 are unrelated to the diagnoses of schizophrenia or depression, but are positively related (at a non-significant level) to the presence of organic features in the patients. The patients' scores in these two categories account for much our meaning when we say that psychiatric patients, as opposed to controls, are originally sick and that later they are better. Category 4, which increases slightly more for schizophrenics than for non-schizophrenics, is in our sample the dimension which discriminates best between patients and non-patients and also shows the greatest increase for the patients during hospitalization. We have described above many aspects of the psychiatric ward on which this research was done which would contribute to this change. It remains to be seen whether these findings will generalize to other settings.

CHAPTER VI

RELATIONS BETWEEN SELF-PERCEPTION AND PERCEPTION BY OTHERS

Results

We have now presented the results concerning the content areas of our patients' self perception, as seen in terms of social desirability scores, correlations between Q-sorts, and category scores and have related these findings to demographic variables and to diagnosis. In this section, we would like to discuss the relationship of the previous findings to two variables related to hospitalization and to observer ratings. Only Q-sorts for self were utilized in these correlations. The first of the two measures (other than observer ratings) to be discussed is the patient's answer, during the initial interview with the psychiatric resident, to the question, "Have you ever felt before the way you felt just before you came to the hospital?" 52 per cent of the patients answered yes to this question, and the significant correlations between this answer and variables derived from the Q-sort are presented in Table 17.

Table 17

Selected Correlations for Patients between "Felt This Way Before" and Q-Sort Variables

Category Correlated	1st Sort r	2nd Sort r	Change (2nd Sort minus 1st Sort) r
Social Desirability	.05[1]	-.61**[1]	-.40[2]
1	-.27	.19	-.01
2	.21	-.50*	-.28
4	-.44*	-.45*	-.20
7	-.53*	-.72***	-.15
8	-.20	-.69***	-.49*
9	.05	-.38	-.41

N=21

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[1] A positive correlation indicates an association of "yes" with high scores.

[2] A positive correlation indicates an association of "yes" with increases in scores.

* $p < .05$ **$p < .01$. ***$p < .001$.

Patients who have had feelings in the past similar to those prior to hospitalization see themselves more negatively in terms of social desirability and on a number of category scores at the time of the second sort. Categories 7 and 8 (external and internal competence) correlate most significantly at the time of the second sort with the response to this question. Category 8 scores increase significantly more for patients who deny previous similar feelings than for patients who acknowledge them. At the time of the first sort patients who had felt the same way before see themselves as significantly lower in categories 4 (sociability) and 7 (external competence), despite the fact that they are seen as more sociable than other patients by nurses and the recreation therapist and as more competent by the recreation therapist ($p < .05$ for all three).

We will now consider the relationships between self perception and total hospital stay. We use as a statistic the number of weeks between the patient's second Q-sort and his discharge. Since the second sort is given at approximately the same time to each patient, the number of weeks between the second Q-sort and discharge gives a reasonably accurate estimate of the total stay. Significant results for this measure are presented in Table 18.

Table 18

Selected Correlations of Number of Weeks from Second Q-Sort to Discharge with Q-Sort Variables

Category Correlated	1st Sort r	2nd Sort r	Change (2nd Sort minus 1st Sort r
Social Desirability	.24	-.22	-.42
3	.28	-.37	-.54*
4	-.05	-.59*	-.46*

N=19

* $p < .05$.

The patient's social desirability scores at either sort do not correlate significantly with total hospital stay. The correlation with increase in social desirability scores between testings falls just short of significance ($p < .06$), in the direction that an increase in scores between testings means that the patient is closer to discharge at the time of the second testing. An increase in scores of categories 3 and 4 (psychological health, sociability) is significantly related to shorter hospital stay. A high score on category 4 at the second sort also indicates that the patient is closer to discharge. A high score on social desirability and several of the categories at the first sort correlated positively with a *longer* hospitalization, although none of the correlations were significant.

The only observer rating at the time of the first sort to correlate significantly with total length of hospitalization was the recreation therapist's rating of social participation ($r = -.47$, $p < .05$), meaning that the patients who participated in social activities early in their hospital stay were discharged sooner than other patients. No other observer rating was a significant predictor of length of hospital stay.

We will now consider the relationship between patient self perception and observations made about the patient's behavior while he is hospitalized. Let us first examine a measure of overall improvement, constructed from the change in the psychiatric resident's overall evaluation of the patient between the second and tenth weeks of hospitalization (i.e., the same weeks during which the patient performed the Q-sort). This measure is related to the number of weeks that the patient remains in the hospital, $r = -.38$, in that patients' rated as improving more at the time of the second Q-sort tend to be discharged sooner, although the correlation is not significant. Table 19 presents the correlations between the

psychiatrists' ratings of overall patient improvement and our measures of patient self perception.

Table 19

Correlations between Psychiatrist's Ratings of Overall Improvement and Q-Sort Variables

Category Correlated	1st Sort r	Change (2nd Sort minus 1st Sort) r
Social Desirability	-.02	.15
1	-.06	-.04
2	-.02	-.08
3	-.34	.44^{x}
4	-.36	.59*
5	-.16	-.12
6	.08	-.24
7	.57*	-.12
8	.53*	-.09
9	-.34	.17

N = 16

x $p < .08$.

* $p < .05$.

The number of patients included in this Table is reduced because one of the five psychiatric residents did not rate his patients on this scale. Both initial social desirability and changes in social desirability scores were unrelated to the psychiatrist's rating. Initial high scores in categories 7 and 8 (external and internal competence) were significantly related to the improvement measure, while initial low scores on categories 3, 4, and 9

(health, sociability, and absence of depression) were related to improvement, although these correlations were not significant. Of more interest, however, is the fact that improvement as rated by the therapist is related to increased scores in only two of the categories, 3 and 4. Category 3 falls short of the .05 level of significance because of the reduced number of patients included. We note that change scores in categories 7 and 8 did not relate to this measure of improvement, nor did category 9. Thus only two components of self perception (sociability and psychological health) reflected an agreement between patients' feelings of improvement and psychiatrists' ratings of overall improvement.

Another measure of improvement which was more limited in scope, patient's improvement in family therapy, correlated $r = .50$ ($p < .05$) with the psychiatrist's improvement measure. This variable was rated jointly by the psychiatrist and the social worker. The only category score to correlate significantly with this measure was category 8 (internal competence). Patient who saw themselves as more competent initially improved more in family therapy $r = .51$ ($p < .05$). Improvement was negatively related to change in this competence score, $r = -.48$ ($p < .05$); that is, patients who improved the most in family therapy saw themselves as increasing the least in internal competence.

We will now present the results of correlations between more specific observation scales and self perception variables. No specific hypotheses were formulated for the relationships between total social desirability and the observation scales, although it was felt that they would generally be positive, especially the correlations between change in social desirability and change in observer ratings on the various scales. In fact, this expectation was not fulfilled.

The patient's initial social desirability did not correlate significantly with any of the observational data from either time period. Changes in social desirability correlated with four measures of depression, as shown in Table 20.

Table 20

Correlations between Observer Ratings of Depression and Increase in Patients' Social Desirability Scores

Scale	First Rating By Observer r	Change in Rating by Observer r
Psychiatrist's Depression Scale	.63**	-.60**
Nurses' Depression Scale	.50*	-.41*

* $p < .05$.
** $p < .01$.

Patients who were initially rated as depressed increased the most during hospitalization in self ratings of social desirability. Increases in social desirability scores also correlated highly with decreases in observed ratings of depression. Change in social desirability scores did not correlate significantly with any other observations of the patients' behavior, except the nurses' scale of "liked by others." Increases in this score correlated positively with increases in social desirability ($r = .55$, $p < .01$).

With the exception of category 2 (self-approval) which was not rated by staff members, each of the category scores was related, often in a rough manner, to a corresponding area of observable behavior, rated by the nurses, the recreation therapist, or the psychiatric resident. These results are presented for each category in Table 21. Category scores,

1st sort, are correlated with observations made during the week of the patient's first sort. Category scores for the second sort were correlated with observations made at the time of that testing.

Table 21

Correlations between Patients' Category Scores and Comparable Observer Ratings[1]

Category and Rating	1st Sort r	2nd Sort r	Change (2nd Sort minus 1st Sort) r
1. Liked by others			
N:[2] Liked by others	-.27	.24	.15
R:[3] Liked by others	-.26	-	.04
3. Psychological health			
P:[4] Overall evaluation	.05	.02	.44[x]
P: Negative score for psychopathology[5]	-.16	.25	.23
P: Neg. score for somatic manifestations	.29	-.06	.51*
N: Neg. score for psychopathology	-.20	-.16	.14
4. Sociability			
R: Social participation	-.23	.25	-.23
N: Social activity	-.20	.61**	.30
5. Positive feelings toward others			
P: Lack of hostility	.11	-.21	-.34
6. Dominance			
R: Leadership	-.02	-.12	.06
7. External competence			
R: Competence	-.12	-.30	.32
8. Internal competence			
R: Self responsibility	.01	-	.11
N: Self responsibility	-.10	-	.27
Minus 9. Depression			
P: Simple depression	.28	-.12	.49*
P: Complex depression	.03	.23	.28
N: Depression	.26	-.05	.36
The average z-scores:	-.04	.07	.21

1. For fuller details of observer rating variables used see Appendix C.
2. N = Nurse; 3. R = Recreation Therapist: 4. P = Psychiatrist.
5. I.e., absence, rather than presence of psychopathology, somatic manifestations, and depression were scored.

x $p < .08$; * $p < .05$; ** $p < .01$.

We find that contrary to our hypothesis, there is no significant increase in the positive correlations between patients' and observers' ratings of the patient at the tenth week as contrasted to the second week of hospitalization. Using change scores, in 14 of the 16 instances the average changes in patient and observer ratings were in the same direction. This trend is possibly of limited significance since patients see themselves as improving in all categories except 6 (dominance) and patients are seen by others as improving in all ratings except psychiatrist's "complex depression". The change in most of the observer scores is not significant.

A further comparison between patients' self image and the way in which patients are seen by others is obtainable from our data. This is the correlation between the patient's Q-sort for self and his parents' sort for patient at each testing period. These results are to be found in Table 22.

Table 22

Correlation between Sorts for Patient by Patient and by Parents

	N	1st Sort		2nd Sort		p
		$\bar{z}$	$\bar{r}$	$\bar{z}$	$\bar{r}$	
Total Parent Group	40	.28	(.27)	.38	(.36)	$< .05$
Parent Group in terms of Patient's Diagnosis						
Schizophrenics	18	.26	(.25)	.33	(.32)	NS
Non-Schizophrenics	22	.29	(.28)	.41	(.39)	$< .05$
Depressives	18	.28	(.27)	.51	(.47)	$< .001$
Non-Depressives	22	.28	(.27)	.27	(.26)	NS

Although the increase in correlations for the total group between the first and second sorts is not large it is significant at the .05 level. There is no difference between patient diagnostic groups at the first

testing. At the time of the second testing there is no increase in patient-parent correlations for the schizophrenic and non-depressive patients, but the increase in the correlation for the depressive patients is highly significant. At the time of the second sort depressives and their parents agree significantly more about what the patient is like than do non-depressives and their parents.

Before we turn to a more detailed analysis of the above correlations, let us examine the hypothesis that there will be increasing agreement among observers during the course of the patient's hospitalization as to what the patient is like. The results comparing psychiatrists', nurses,' and recreation therapists' ratings are shown in Table 23.

Table 23

Correlations Between Observer Ratings of Patients at Each Time Period

	1st Rating	2nd Rating	Change (2nd Rating minus 1st Rating)
Sociability (N:R)[1]	.60**	.52*	.41*
Self responsibility (N:R)	.31	-	.29
Psychopathology (P:N)[2]	.58**	.17	.51*
Liked by others (N:R)	.41	-	-.01
Depression (P:N)	.53**	.31	.47*
Depression (N): Complex Depression (P)	.33	-.26	.25

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1. N = Nurse; R = Recreation therapist.
2. P = Psychiatrist

* $p < .05$.

** $p < .01$.

Contrary to our hypothesis, observers of the patient's behavior disagree more at the time of the tenth hospital week than at the second. Although none of the differences between first and second observations periods are

significant, the difference between average z-scores (second correlation minus first correlation) for the four inter-observer correlations that were rated at both testing periods. This indicated at least a trend for greater disagreement among observers later in the patients' hospital course.

Our other group of observers, the patients' parents, confirms this finding, although to a lesser extent. The average z-scores for the correlation between sorts for the patient by the patient's mother and the patient's father are .51 ($p \angle .05$) and .46 ($p \angle .05$) for first and second sorts respectively. There were no differences between the diagnostic groupings of patients.

With this background in the results concerning the observer ratings, let us return to the question of correlations between observer scales and category scores. It was noted in the preparation of Table 21 that not only were the predicted correlations relatively low, but they also were not the highest correlations between the observer scale and the categories. Of the 45 correlations tabulated, only in six did the predicted category correlate more highly with observer variables than other category scores (thrice for category 3, twice for category 4 and once for category 9). It was then noted that there were specific categories which seemed to correlate most highly with all the observation scales rated by one type of observer. For example, at the time of the first testing, category 5 (positive feelings towards others) correlated more highly than any other category with each of the five different ratings of the patients' behavior made by the nurses. Table 24 demonstrates the extent of this pattern.

Table 24

Category Correlating Highest with All Ratings by One Type of Observer

Observer	Category	Number of Highest Ratings
Psychiatrist		
1st Sort	6	4 out of possible 7[1]
2nd Sort	4	5 out of 7[2]
Change (2nd Sort minus 1st Sort)	4	5 out of 7[2]
Nurse		
1st Sort	5	5 out of 5
2nd Sort	4	3 out of 4
Change	4	4 out of 5
Recreation Therapist		
1st Sort	1,5	4 out of 4
2nd Sort	4	4 out of 4
Change	2	4 out of 4

1. Two of the three remaining ratings correlated most highly with other categories with which it had been predicted they would relate.

2. One of the two remaining ratings correlated most highly with an other category with which it had been predicted it would relate.

Excluding the six predicted correlations, one category correlated highest with, at the least, all but one of the scales rated by one type of observer that were scored and set up for statistical work. The magnitude of the difference in predictive ability between the "predicted" category and the single highest correlating category for each observer can be estimated by comparing the average correlations between each type of category and all observer ratings at each time period. The average z-scores using the "highest correlating" category for each type of observer are, .30, .25, .47,

for the 1st sort, 2nd sort, and change respectively, as contrasted to the average z-scores of -.04, .07, .21 from the predicted correlations in Table 21. In contrast to other results in this study, neither category 3 (psychological health) nor category 9 (absence of depression) correlated highly with multiple observer ratings. Category 4 (sociability) was the most important, correlating with five of nine sets of observer ratings, while four other categories each correlated highest with one type of observer rating. It is interesting to note that at the time of the second sort there is a significant correlation ($r = .53$, $p < .05$) between the recreation therapists' rating of sociability and the psychiatrists' overall evaluation. Except for the second sort, there is no uniformity among the groups of observers. Disregarding for the moment the specific categories involved in these correlations, we must conclude that there is a lack of specificity and discrimination in the way observers use scales in rating patients. The reverse of this situation did not occur, that is no one observer rating correlated highly with all of the category scores, although the various depression ratings (by the psychiatrists) together did correlate best with about half of the category scores. This result implies that patients are apparently more discriminating in their self observations than outside observers are in rating the patient. Of course, this result is not in itself evidence for the accuracy of the patients' self observations.

The importance of sociability both to the patient and to the ward personnel has been discussed above. It is significant then that the variable of sociability seems to encompass (or be an index of) many divergent aspects of the patients' behavior as rated by the ward staff.

Discussion

In our data, as well as in previous studies reported by others, there is a tendency for results of self observations to relate to other results of self observations, and observations by others to relate to other "objective" criteria, but for the relation between the two types of data to be much weaker. We correlated social desirability scores and category scores with the subjective report on "Have you ever felt this way before?", and with objective measures of number of previous hospitalizations, number of previous psychiatrists, and time spent in psychotherapy. There are eight significant correlations between the subjective measure and the Q-sort variables, while for the three objective measures there is only one correlation significant at the .05 level.

We might tentatively equate an affirmative answer to "Have you felt this way before?" with the patients' having experienced previous episodes of illness. It is then possible to infer that previous episodes of illness (in terms of the patients' feelings) lead patients to see themselves less highly after ten weeks of hospitalization. This view perhaps indicates that the patient's confidence in his own abilities is undermined, particularly as the greatest difference which distinguishes those patients who have felt the same way previously is in the area of felt competence (categories 7 and 8). Another way of considering this finding is that patients who "have been through it all before" are less impressed with the changes in themselves. In particular, category 8 improves significantly less for these patients during hospitalization. They may be more inclined to see the hospital's role as helping them cope with a recurrent acute problem (which they have perhaps dealt with in other ways before) rather than as effecting a basic change in their personality organization. Patients who have experienced the same feelings

previously are seen by the psychiatrist as somewhat less improved ($r = -.35$) during hospitalization. These patients also describe themselves as lower in competence in handling external problems and in sociability (categories 7 and 4) at the initial testing. Their self-rating may be the result of previous episodes of illness which have cut them off from interactions with others. Their feelings would be very important in determining the patient's initial reaction to a ward setting in which he is expected to be sociable and to exhibit at least certain areas of competency. These patients did not, however, differ from others in the total length of hospital stay. Objective measurements of previous illness also do not correlate with length of hospital stay.

Initial social desirability and category scores are not reliable predictors of the length of the patient's hospital stay. In this case, however, neither observational data nor background variables are more effective in providing this type of prognosis. The only rating which does predict hospital stay is the recreation therapist's judgment of social participation. This is one of several clues to the importance of this type of behavior on the part of the patient within this hospital setting. In a ward in which social interaction is a prime value, this aspect of the patient's behavior is a reflection of his acceptance and integration in the entire therapeutic program. It may also be a reflection of his ability to adapt to the particular kind of environment in which he is placed, including both the structured aspects of in-patient life and the ward values. His adaptation enables the patient to progress more quickly through the course of graded steps towards discharge. Earlier discharge occurs despite the fact that at the time of the second Q-sort these patients are not seen by the psychiatrist as more improved than other patients.

Patients who have a greater initial feelings of competence are seen as improving more by the psychiatrist, although total social desirability does not correlate with this rating. A suggestion has been made by Kaplan et al (1964) that high self esteem could lead to greater participation in therapy. Although we were not able to substantiate this result in terms of total social desirability, our competence scores may be reflecting such a tendency. The importance of social participation is again emphasized by the significant correlation between increase in sociability as seen by the patient and improvement as rated by the psychiatrist. This may also reflect the fact that group therapy sessions outnumber individual therapy sessions on this ward. What is seen by the therapist as greater benefit from therapy may be seen by the patient as more extensive social interaction. In fact, this increase in social interaction may be one of the major benefits which the patient receives from this type of short term hospital treatment. The patient's perception of his improvement in psychological health (category 3) correlates with psychiatrist's rating of improvement at a level just short of significance.

We note that there is a very small correlation between psychiatrist's rating of improvement and increase in social desirability scores. In conjunction with the results in Table 20 which show the strong association of social desirability scores with ratings of depression, we will re-emphasize our belief that the social desirability score is more related to depression than to non-specific mental illness or maladjustment.

We were disappointed to find that in the specific ratings our study was no more successful than previous research in attempting to relate self perception to perception by others. Although there were a few significant positive correlations, particularly in areas of sociability and depression,

even these were not consistent. Because the observer ratings were not made with the Q-sort technique, we were not able to correct for differences in social desirability scores between patients and observers, as suggested by Kogan _et al_ (1957). The findings presented in Table 24 cast some doubt as to the independence of diverse ratings by a single observer of rating of patients which is obtainable from our rating charts and the scoring system which we have applied to them. Yet we also note that (at least at the time of the first Q-sort) correlations between observer ratings for the same dimension were generally high. The possibility remains that the subjective and observational variables used cannot be equated because they vary along non-parallel axes.

We found that our prediction that the patient and outside observers would agree more on what the patient is like, later in the course of the patient's hospital stay, is not confirmed at the .05 level of significance although there is a trend in the predicted direction for ward personnel. There is increasing agreement between the patient and his parents as to what the patient is like. We had expected a greater congruence between patient and observer ratings of the patient on the basis of three assumptions: first, that there is a period of greater exposure of the patient to his observers, leading to correction of initial misperceptions; second, that as the patient's therapy progresses, it is assumed that he gives verbal expressions of his ideas and affects which are more direct and closer to his inner feelings, again leading to a truer perception of him by others; third, that there would be an influence in the reverse direction, of the patient's self perception being modified by the "mirror" responses of others, and the general ward emphasis on correcting patients' notions about their own behavior.

We had expected that as a corollary of the above hypotheses there would be greater agreement between observers, partly on the basis that each would be less blind in his perception of the "elephant" of the self, and the picture that each would build of the patient would be therefore more congruent with the picture by others. In fact, the opposite occurred, significantly for the ward personnel and non-significantly for the patients' parents. One possible explanation that we might provide post hoc is that with a decrease in psychopathology, the patient's behavior becomes less rigid and more amenable to shifts in environmental requirements. The thesis has been held by some observers that patients in some ways are more predictable in their behavior than normals, and that they overgeneralize in their responses to social stimuli. If a greater flexibility were to occur during hospitalization, it is possible that on this basis there would be a greater disagreement between observers who see the patient in different environmental contexts. Stereotyped ideas about a patient based on his diagnosis may account for a greater proportion of his behavior initially than after the reduction of many of the acute symptoms.

Another possibility is that in the first few weeks of hospitalization there is much more intense observation and discussion of the patient among staff members, leading to a moderate consensus among observers. Later on during hospitalization, interest and discussion of the patient diminish, and observers are less apt to be influenced by the group consensus about the patient.

SUMMARY

The construct of the self was reviewed as it is conceptualized by sociological, psychological, and psychoanalytic theory. Others have theorized that the origin of the self concept lies in both reflected appraisals by others and in internal perceptions of feelings and thoughts. The self is seen to motivate behavior, to experience itself, and to perceive itself. The function of self perception is the aspect which has been examined in this study.

In a group of 22 adolescent acute psychiatric inpatients, the positive valuation of the self increased between the second and tenth weeks of hospitalization, as measured by means of Q-sort correlations between self and ideal self. In addition, the social desirability of their Q-sorts for self also increased significantly. The social desirability scores of the 22 patients were significantly lower than a comparison group of "normal" college students. In contrast to the results of previous work, the adjustment or social desirability score for the self image did not relate to global measures of sickness or mental illness, but was related to depression. Changes in self evaluation occurred in all sub-groups of patients, but depressive patients increased their positive evaluation of self more than non-depressive patients. There was also evidence that a more basic reorganization took place in the self concept of the schizophrenic patients compared with non-schizophrenic patients. Depressive patients showed a relatively greater change in their image of their ideal self than schizophrenics or non-depressives.

Self perception changed most significantly during hospitalization in the areas of depression, sociability, and competence in handling external problems. Of the nine components of self perception examined, there were significant correlations between patient self-ratings and staff ratings of the patient only for depression and sociability. There was also significant agreement among staff members about the patients' behavior in these two areas as well as in the area of psychopathology.

Neither the total social desirability score nor any of the components of self perception rated by the patients at the second week of hospitalization were predictive of the patient's hospital course. Changes between the two testings in the patient's perception of his own psychological health and sociability correlated significantly with psychiatrist's ratings of improvement and with the duration of the patient's hospital stay. The patient's self rating of his sociability also correlated highly with a large number of observer ratings of the patient's behavior on many dimensions. The values and goals of the psychiatric ward on which this study was performed provided a partial explanation for the importance in our study of the patient's perception of his own sociability.

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APPENDIX A

THE PATIENT SAMPLE

APPENDIX A

THE PATIENT SAMPLE

Patient Code	Admission Diagnosis	Discharge Diagnosis
001	anorexia nervosa	same
010	schizophrenic reaction, acute, undifferentiated	same
011	psychotic depressive reaction with organic features related to barbituate intoxication	depressive reaction, psychotic, in a cyclothymic personality
013	depressive reaction; passive dependent hysterical character	same
014	depressive reaction; hysterical and schizoid personality	depressive reaction
016	sociopathy with underlying borderline state	adolescent adjustment reaction
017	depression; borderline schizophrenia	same
018	borderline psychotic state with hysterical and depressive features	depressive reaction; hysterical personality; borderline schizophrenia
019	schizophrenic reaction, acute, undifferentiated	same
020	depressive reaction; psychomotor epilepsy	depressive reaction; psychomotor epilepsy; low normal intelligence
021	early schizophrenic reaction	depressive reaction

Patient Code	Admission Diagnosis	Discharge Diagnosis
023	schizophrenic reaction	schizophrenic reaction; schizoid personality
024	fugue state; narcolepsy	conversion reaction with depressive features
025	anorexia nervosa	anorexia nervosa; neurotic depression
026	conversion reaction; migraine syndrome	conversion reaction; immature personality
027	adjustment reaction with depressive features	same
028	neurotic depression	same
029	passive dependent personality; psychophysiologic gastrointestinal reaction	same
030	convulsive disorder; schizophrenia	same
031	chronic schizophrenia	same
032	schizophrenia with depressive features; rule out organic syndrome	schizophrenic reaction, chronic, undifferentiated
034	possible seizure disorder; borderline psychotic	schizophrenic reaction, paranoid type; basic sociopathic values; chronic depression

APPENDIX B

CODINGS OF Q-SORT ITEMS ON SOCIAL DESIRABILITY AND THE NINE CATEGORIES

ITEM LOADINGS ON SOCIAL DESIRABILITY

DESCRIBING YOURSELF

The more the sentence is like you, the higher the number you give it.
The more the sentence is unlike you, the lower the number you give it.

1 = most UNLIKE you
2 = quite UNLIKE you
3 = fairly UNLIKE you
4 = somewhat UNLIKE you
6 = somewhat LIKE you
7 = fairly LIKE you
8 = quite LIKE you
9 = most LIKE you
5 = IN BETWEEN: neither like you or unlike you

+ I am likeable.

+ I am contented.

− I just don't respect myself.

+ I am satisfied with myself.

− I am worthless.

N I feel superior.

− I have a feeling of hopelessness.

+ I understand myself.

+ I feel emotionally mature.

+ I make strong demands on myself.

+ I express my emotions freely.

− I am often down in the dumps.

+ I have an attractive personality.

− I am disorganized.

− I often feel guilty.

− I have the feeling I'm just not facing things.

+ My personality is attractive to the opposite sex.

+ I am liked by most people who know me.

− I put on a false front.

− I am shy.

+ I am sexually attractive.

N Usually in a mob of people I feel a little alone.

− I often feel humiliated.

+ I can usually make up my mind and stick to it.

− I don't trust my emotions.

DESCRIBING YOURSELF

The more the sentence is like you, the higher the number you give it.
The more the sentence is unlike you, the lower the number you give it.

1 = most UNLIKE you
2 = quite UNLIKE you
3 = fairly UNLIKE you
4 = somewhat UNLIKE you
6 = somewhat LIKE you
7 = fairly LIKE you
8 = quite LIKE you
9 = most LIKE you
5 = IN BETWEEN: neither like you or unlike you

N	I am just sort of stubborn
+	I am a responsible person.
−	I feel inferior.
N	I am critical of people.
−	I have a horror of failing in anything I want to accomplish.
+	I am intelligent.
+	I usually like people.
−	It is pretty tough to be me.
−	I feel helpless.
+	Self control is no problem to me.
+	I am ambitious.
−	I really am disturbed.
N	I often kick myself for the things that I do.
−	I am afraid of sex.
+	I feel relaxed and nothing really bothers me.
+	I can live comfortably with the people around me.
−	I am confused.
−	All you have to do is just insist with me and I give in.
N	My hardest battles are with myself.
−	I am unreliable.
−	I am a failure.
+	I take a positive attitude toward myself.
+	It's important for me to know how I seem to others.
−	I can't seem to make up my mind one way or another.
+	I am a hard worker.

ITEM CODING ON CATEGORY SCORES, WITH LOADINGS

DESCRIBING YOURSELF

The more the sentence is like you, the higher the number you give it.
The more the sentence is unlike you, the lower the number you give it.

1 = most UNLIKE you
2 = quite UNLIKE you
3 = fairly UNLIKE you
4 = somewhat UNLIKE you

6 = somewhat LIKE you
7 = fairly LIKE you
8 = quite LIKE you
9 = most LIKE you

5 = IN BETWEEN: neither like you or unlike you

+ 2 I am likeable.

+ 9 I am contented.

− 2 I just don't respect myself.

+ 2 I am satisfied with myself.

− 2 I am worthless.

+ 2 I feel superior.

− 9 I have a feeling of hopelessness.

+ 3 I understand myself.

+ 3 I feel emotionally mature.

+ 8 I make strong demands on myself.

+ 4 I express my emotions freely.

− 9 I am often down in the dumps.

+ 2 I have an attractive personality.

− 7,8 I am disorganized.

− 9 I often feel guilty.

− 7,8 I have the feeling I'm just not facing things.

+ 1,2 My personality is attractive to the opposite sex.

+ 1 I am liked by most people who know me.

− 4 I put on a false front.

− 4 I am shy.

+ 2 I am sexually attractive.

− 4 Usually in a mob of people I feel a little alone.

− 9 I often feel humiliated.

+ 8 I can usually make up my mind and stick to it.

− 8 I don't trust my emotions.

DESCRIBING YOURSELF

The more the sentence is like you, the higher the number you give it.
The more the sentence is unlike you, the lower the number you give it.

1 = most UNLIKE you
2 = quite UNLIKE you
3 = fairly UNLIKE you
4 = somewhat UNLIKE you
5 = IN BETWEEN: neither like you or unlike you
6 = somewhat LIKE you
7 = fairly LIKE you
8 = quite LIKE you
9 = most LIKE you

+ 6 I am just sort of stubborn

+ 7 I am a responsible person.

− 2 I feel inferior.

− 5 I am critical of people.

− 7,8 I have a horror of failing in anything I want to accomplish.

+ 2 I am intelligent.

+ 5 I usually like people.

− 2,9 It is pretty tough to be me.

− 7,8 I feel helpless.

+ 8 Self control is no problem to me.

+ 7 I am ambitious.

− 3 I really am disturbed.

− 2 I often kick myself for the things that I do.

− 4,5,9 I am afraid of sex.

+ 9 I feel relaxed and nothing really bothers me.

+ 5,9 I can live comfortably with the people around me.

− 3 I am confused.

− 6 All you have to do is just insist with me and I give in.

− 8 My hardest battles are with myself.

− 7 I am unreliable.

− 2,7 I am a failure.

+ 2 I take a positive attitude toward myself.

+ 1 It's important for me to know how I seem to others.

− 8 I can't seem to make up my mind one way or another.

+ 7 I am a hard worker.

APPENDIX C

OBSERVER RATING SCALES AND THEIR CODING

ADDRESSOGRAPH:

GRACE-NEW HAVEN COMMUNITY HOSPITAL

PSYCHIATRIC INPATIENT DIVISION
PSYCHIATRIST'S WEEKLY EVALUATION
RATER____________________
WEEK ENDING____________________

DEGREE OF INTERFERENCE IN KEY AREAS

1	2	3	4	5	6	7	8	9
NO INTERFERENCE AT ALL		SOME INTERF. BUT NOT MUCH		MOD. AMT. OF INTERF.		QUITE A BIT OF INTERF.		A VERY GREAT AMT. OF INTERF.

	INDIVIDUAL CONTACTS WITH THERAPIST	PT.-FAMILY CONF. AND OTHER PT-FAMILY CONTACTS	PT.-FAMILY GROUP THERAPY	PT. GROUP THERAPY
I. OVERALL EVALUATION				
I. INTERFERENCE BY:				
1. OVERT DISPLAY OF ANXIETY				
2. PHOBIAS				
3. COMPULSIVITY OR OBSESSIONS				
4. HYPOCHONDRIASIS OR SOMATIZATION OR CONVERSION SYMPTOMS				
5. HISTRIONIC BEHAVIOR				
6. RULE BREAKING BEHAVIOR				
7. POOR SOCIAL JUDGMENT				
8. SEXUAL THOUGHTS				
9. INAPPROPRIATE SEXUAL ACTIVITY				
0. OVERTLY AGGRESSIVE BEHAVIOR				
1. VERBAL HOSTIL. OR NEGATIVISM				
2. ADDICTIONS OR ALCOHOL (UNDERLINE)				
3. DEPRESSED MOOD				
4. ELEVATED MOOD				
5. RETARDATION				
6. LACK OF INITIATIVE				
7. HYPERACTIVITY				
8. ISOLATION				
9. WITHDRAWAL				
0. REGRESSIVE BEHAVIOR				
1. PARANOID THOUGHTS				
2. BIZARRE SPEECH OR BEHAVIOR				
3. DELUSIONS				
4. HALLUCINATIONS (SPECIFY)				
5. DISORIENTATION OR CONFUSION				
6. INTELLECTUAL IMPAIRMENT				
7. PHYSICAL ILLNESS (INCLUDE SEIZURES & SPEECH IMPRMNT & ANY OTHER, AND SPECIFY).				

F455 (NEW 4/64)

GRACE-NEW HAVEN COMMUNITY HOSPITAL

Addressograph:

Psychiatric Inpatient Division
Nurse's Observation Sheet
Week # (for pt. on T-I): ______
Week Beginning: ______________

I. Day Shift:
Rater: M_____ T_____ W_____ T_____
F_____ S_____ S_____

A. RATER'S DISCOMFORT ABOUT PATIENT'S PSYCHIATRIC CONDITION

	M	T	W	T	F	S	S
1-very uncomfortable	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-somewhat uncomfortable	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-not uncomfortable at all	5	5	5	5	5	5	5

B. TIME SPENT IN BED DURING DAY

	M	T	W	T	F	S	S
1-a great deal	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none	5	5	5	5	5	5	5

C. CONFUSION

	M	T	W	T	F	S	S
1-a great deal	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none	5	5	5	5	5	5	5

D. AMOUNT OF VERBALIZATION

	M	T	W	T	F	S	S
1-very little	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-average amount	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-quite overtalkative	5	5	5	5	5	5	5

E. EATING

	M	T	W	T	F	S	S
1-very little or none	1	1	1	1	1	1	1
2-	2	2	2	2	2	2	2
3-normal	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-an enormous amount	5	5	5	5	5	5	5

F. PATIENT INITIATES CONTACT WITH OTHER PATIENTS

	M	T	W	T	F	S	S
1-none	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-a great deal	5	5	5	5	5	5	5

G. DEPRESSED MOOD

	M	T	W	T	F	S	S
1-extremely	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-somewhat	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-not at all	5	5	5	5	5	5	5

H. NERVOUSNESS OR TENSENESS

	M	T	W	T	F	S	S
1-a great deal	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none	5	5	5	5	5	5	5

I. ABLE TO TAKE RESPONSIBILITY FOR OTHER PTS.

	M	T	W	T	F	S	S
1-not responsible at all	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-somewhat responsible	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-very responsible	5	5	5	5	5	5	5

J. ABLE TO TAKE RESPONSIBILITY FOR SELF

	M	T	W	T	F	S	S
1-not responsible at all	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-somewhat responsible	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-very responsible	5	5	5	5	5	5	5

K. OVERALL MOTOR ACTIVITY

	M	T	W	T	F	S	S
1-very little	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-normal	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-overactive	5	5	5	5	5	5	5

L. CHANGES IN CLINICAL CONDITION

	M	T	W	T	F	S	S
1-worse in afternoon	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-same all day	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-worse in morning	5	5	5	5	5	5	5

M. DEPRESSIVE VERBALIZATIONS

	M	T	W	T	F	S	S
1-a great deal	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none	5	5	5	5	5	5	5

Form No. 1268 New 10/63

. Day and Evening Shift:

. DISTURBED BEHAVIOR	M	T	W	T	F	S	S
nying obvious problems							
ose to crying							
ying							
acing							
gitated							

. DISTURBED BEHAVIOR (contd)	M	T	W	T	F	S	S
appropriate clothing							
eductive							
randiose							
anicky							

. DISTURBED BEHAVIOR (contd.)	M	T	W	T	F	S	S
omatic preoccupation							
earful							
uspicious							
lat affect							
appropriate affect							

. POOR REALITY CONTACT	M	T	W	T	F	S	S
luctuating reality contact							
elusions suspected							
elusions present							
allucinations suspected							
allucinations present							

. ACTING OUT BEHAVIOR	M	T	W	T	F	S	S
reatening talk or behavior							
ysterical outbursts							
estructive outbursts							
ggressive behavior							

. ELOPEMENT OR SUICIDE	M	T	W	T	F	S	S
lopement talk							
rief elopement attempt							
lopement (over ½ hour)							
uicide talk							
uicide attempt							

. SOMATIC SYMPTOMS AND IDE EFFECTS	M	T	W	T	F	S	S
lurred vision							
asal congestion							
ore throat							
ry mouth							
ashes							

. SOMATIC SYMPTOMS AND IDE EFFECTS (contd.)	M	T	W	T	F	S	S
onstipation							
iarrhea							
omiting							
ausea							
bdominal pains							

. SOMATIC SYMPTOMS AND IDE EFFECTS (contd.)	M	T	W	T	F	S	S
etarded movements							
eadaches							
eakness							
izziness							
eizures							

J. PARKINSONIAN SYMPTOMS	M	T	W	T	F	S	S
tremor							
akathisia							
rigidity							
dyskinesia							

K. STAFF-INITIATED ACTIVITIES	M	T	W	T	F	S	S
pass							
used buddy system							
on buddy system							
on modified buddy system							
5-minute checks							
specialed							

L. OFF-WARD ACTIVITIES	M	T	W	T	F	S	S
part-time work (less than 3 hrs)							
part-time work (3-5 hrs)							
part-time work (over 5 hrs)							
day pt.							
night pt.							

III. Evening Shift:

Rater: M_____ T_____ W_____ T_____
F_____ S_____ S_____

A. PATIENT'S PRESENT PSYCHIATRIC CONDITION	M	T	W	T	F	S	S
1-very sick	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-moderately sick	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-not sick at all	5	5	5	5	5	5	5

B. TIME SPENT SOCIALIZING WITH PATIENTS	M	T	W	T	F	S	S
1-none	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-less than average for T-1	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-average for T-1 or more	5	5	5	5	5	5	5

C. NUMBER OF PATIENTS SOCIALIZED WITH	M	T	W	T	F	S	S
1-none	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-a few	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-a great many	5	5	5	5	5	5	5

D. PATIENT INITIATES CONTACT WITH OTHER PATIENTS	M	T	W	T	F	S	S
1-none	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-a great deal	5	5	5	5	5	5	5

Addressograph:

vening Shift (contd.)

. OTHERS INITIATE CONTACT ITH PT.

	M	T	W	T	F	S	S
-none	1	1	1	1	1	1	1
	2	2	2	2	2	2	2
-some	3	3	3	3	3	3	3
	4	4	4	4	4	4	4
-a great deal	5	5	5	5	5	5	5

. LIKED BY OTHER PTS.

-not at all	1	1	1	1	1	1	1
	2	2	2	2	2	2	2
-a moderate amount	3	3	3	3	3	3	3
	4	4	4	4	4	4	4
-a great deal	5	5	5	5	5	5	5

. ISOLATED FROM OTHER PTS.

-extremely isolated	1	1	1	1	1	1	1
	2	2	2	2	2	2	2
-somewhat isolated	3	3	3	3	3	3	3
	4	4	4	4	4	4	4
-not isolated at all	5	5	5	5	5	5	5

. TIME SPENT WITH STAFF

-none	1	1	1	1	1	1	1
	2	2	2	2	2	2	2
-some	3	3	3	3	3	3	3
	4	4	4	4	4	4	4
-a great deal	5	5	5	5	5	5	5

I. CONFUSION

1-a great deal	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none	5	5	5	5	5	5	5

J. NERVOUSNESS OR TENSENESS

1-a great deal	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none	5	5	5	5	5	5	5

K. BIZARRE SPEECH OR BEHAVIOR

1-a great deal	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none	5	5	5	5	5	5	5

L. ANY TYPE OF SOCIALLY INAPPROPRIATE BEHAVIOR

1-a great deal	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none	5	5	5	5	5	5	5

M. DEPRESSED MOOD

1-extremely	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-somewhat	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-not at all	5	5	5	5	5	5	5

N. VISITING

	M	T	W	T	F	S	S
one friend	_	_	_	_	_	_	_
more than 1 friend	_	_	_	_	_	_	_
1 relative	_	_	_	_	_	_	_
2 or 3 relatives	_	_	_	_	_	_	_
more than 3 relatives	_	_	_	_	_	_	_

O. (IF VISITED) ANY DIFFICULTIES DURING VISIT

1-a great deal	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-some	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none at all	5	5	5	5	5	5	5

IV. Night Shift:

Rater: M_____ T_____ W_____ T_____

F_____ S_____ S_____

A. REQUIRED EXTRA MEDICATION FOR SLEEP

	M	T	W	T	F	S	S
	_		_		_		_
		_		_		_	

B. HAS FALLEN ASLEEP BY

1-12:15 A.M.	1	1	1	1	1	1	1
2- 1:00 A.M.	2	2	2	2	2	2	2
3- 2:30 A.M.	3	3	3	3	3	3	3
4- 4:00 A.M.	4	4	4	4	4	4	4
5-still awake at 4:00 A.M.	5	5	5	5	5	5	5

C. WAKING UP IN MIDDLE OF NIGHT

1-many times	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3-more than once	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5-none	5	5	5	5	5	5	5

D. IN MORNING, AWAKE BEFORE

1-5:00 A.M.	1	1	1	1	1	1	1
2-5:30 A.M.	2	2	2	2	2	2	2
3-6:00 A.M.	3	3	3	3	3	3	3
4-6:30 A.M.	4	4	4	4	4	4	4
5-still asleep at 6:30 A.M.	5	5	5	5	5	5	5

E. BLOOD PRESSURE

highest BP

M_____ T_____ W_____ T_____

F_____ S_____ S_____

lowest BP

M_____ T_____ W_____ T_____

F_____ S_____ S_____

Addressograph:

YALE-NEW HAVEN HOSPITAL

ddressograph:

Psychiatric Inpatient Division
Recreational Therapist's Rating Chart

Rater ____________ Month ____________
Date of First Rating ____________

Patient in Hospital:	Week				
	1	2	3	4	5
1 - All Week	1	1	1	1	1
2 - Most of Week	2	2	2	2	2
3 - Less than ½ of Week	3	3	3	3	3

I. PATIENT'S PRESENT PSYCHIATRIC CONDITION

	Week				
	1	2	3	4	5
1-extremely sick	1	1	1	1	1
2-	2	2	2	2	2
3-quite sick	3	3	3	3	3
4- ①	4	4	4	4	4
5-moderately sick	5	5	5	5	5
6-	6	6	6	6	6
7-slightly sick	7	7	7	7	7
8-	8	8	8	8	8
9-not sick at all	9	9	9	9	9

II. OVERALL WARD ACTIVITIES

A. MOTOR COORDINATION

1-a great deal below average	1	1	1	1	1
2-	2	2	2	2	2
3-quite a bit below average	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount below average ②	5	5	5	5	5
6-	6	6	6	6	6
7-slightly below average	7	7	7	7	7
8-	8	8	8	8	8
9-average or better	9	9	9	9	9

B. DIFFICULTY IN ATTENTION OR IN FOLLOWING INSTRUCTIONS

1-a very large amount	1	1	1	1	1
2-	2	2	2	2	2
3-quite a bit	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount ③	5	5	5	5	5
6-	6	6	6	6	6
7-a slight amount	7	7	7	7	7
8-	8	8	8	8	8
9-none at all	9	9	9	9	9

C. NON-GROUP FOCUSSED INDIVIDUAL ACTIVITIES

1-a very large amount	1	1	1	1	1
2-	2	2	2	2	2
3-quite a bit ④	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount	5	5	5	5	5
6-	6	6	6	6	6
7-a slight amount	7	7	7	7	7
8-	8	8	8	8	8
9-none at all	9	9	9	9	9

III. OVERALL RESPONSIBILITY ON WARD

A. ABLE TO TAKE RESPONSIBILITY FOR SELF ⑤

	Week				
	1	2	3	4	5
1-not responsible at all	1	1	1	1	1
2-	2	2	2	2	2
3-slightly responsible	3	3	3	3	3
4-	4	4	4	4	4
5-moderately responsible	5	5	5	5	5
6-	6	6	6	6	6
7-quite responsible	7	7	7	7	7
8-	8	8	8	8	8
9-extremely responsible	9	9	9	9	9

B. ABLE TO TAKE RESPONSIBILITY FOR OTHERS ⑥

1-not responsible at all	1	1	1	1	1
2-	2	2	2	2	2
3-slightly responsible	3	3	3	3	3
4-	4	4	4	4	4
5-moderately responsible	5	5	5	5	5
6-	6	6	6	6	6
7-quite responsible	7	7	7	7	7
8-	8	8	8	8	8
9-extremely responsible	9	9	9	9	9

C. HELPS DISORGANIZED OR DISTURBED PATIENTS

1-not at all ⑦	1	1	1	1	1
2-	2	2	2	2	2
3-a slight amount	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount	5	5	5	5	5
6-	6	6	6	6	6
7-quite a bit	7	7	7	7	7
8-	8	8	8	8	8
9-a very great deal	9	9	9	9	9

IV. ORGANIZED GROUP ACTIVITIES

A. PARTICIPATES IN SOCIAL GROUP ACTIVITIES (IN GENERAL)

1-never	1	1	1	1	1
2- ⑧	2	2	2	2	2
3-seldom	3	3	3	3	3
4-	4	4	4	4	4
5-with moderate frequency	5	5	5	5	5
6-	6	6	6	6	6
7-frequently	7	7	7	7	7
8-	8	8	8	8	8
9-almost always	9	9	9	9	9

Week

B. ASSUMES LEADERSHIP ROLE

⑨

	1	2	3	4	5
1-never	1	1	1	1	1
2-	2	2	2	2	2
3-seldom	3	3	3	3	3
4-	4	4	4	4	4
5-with moderate frequency	5	5	5	5	5
6-	6	6	6	6	6
7-frequently	7	7	7	7	7
8-	8	8	8	8	8
9-almost always	9	9	9	9	9

C. RESISTANCE TO GROUP PRESSURE

⑩

1-a very large amount	1	1	1	1	1
2-	2	2	2	2	2
3-quite a bit	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount	5	5	5	5	5
6-	6	6	6	6	6
7-a slight amount	7	7	7	7	7
8-	8	8	8	8	8
9-none	9	9	9	9	9

D. SPEAKS IN ADVISORY BOARD MEETINGS (IF PRESENT)

⑪

1-not at all	1	1	1	1	1
2-	2	2	2	2	2
3-a slight amount	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount	5	5	5	5	5
6-	6	6	6	6	6
7-quite a bit	7	7	7	7	7
8-	8	8	8	8	8
9-a very great deal	9	9	9	9	9

E. DISTURBED ADVISORY BOARD PARTICIPATION (IF PARTICIPATES)

⑫

1-extremely disturbed	1	1	1	1	1
2-	2	2	2	2	2
3-quite disturbed	3	3	3	3	3
4-	4	4	4	4	4
5-moderately disturbed	5	5	5	5	5
6-	6	6	6	6	6
7-slightly disturbed	7	7	7	7	7
8-	8	8	8	8	8
9-not disturbed at all	9	9	9	9	9

F. DISRUPTS ADVISORY BOARD MEETINGS (IF PARTICIPATES)

⑬

1-extremely disruptive	1	1	1	1	1
2-	2	2	2	2	2
3-quite disruptive	3	3	3	3	3
4-	4	4	4	4	4
5-moderately disruptive	5	5	5	5	5
6-	6	6	6	6	6
7-slightly disruptive	7	7	7	7	7
8-	8	8	8	8	8
9-not disruptive at all	9	9	9	9	9

Week

G. SPEAKS IN PT-STAFF MEETINGS (IF PRESENT)

⑭

	1	2	3	4	5
1-not at all	1	1	1	1	1
2-	2	2	2	2	2
3-a slight amount	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount	5	5	5	5	5
6-	6	6	6	6	6
7-quite a bit	7	7	7	7	7
8-	8	8	8	8	8
9-a very great deal	9	9	9	9	9

H. DISTURBED PT-STAFF PARTICIPATION (IF PARTICIPATES)

⑮

1-extremely disturbed	1	1	1	1	1
2-	2	2	2	2	2
3-quite disturbed	3	3	3	3	3
4-	4	4	4	4	4
5-moderately disturbed	5	5	5	5	5
6-	6	6	6	6	6
7-slightly disturbed	7	7	7	7	7
8-	8	8	8	8	8
9-not disturbed at all	9	9	9	9	9

I. DISRUPTS PT-STAFF MEETINGS (IF PARTICIPATES)

⑯

1-extremely disruptive	1	1	1	1	1
2-	2	2	2	2	2
3-quite disruptive	3	3	3	3	3
4-	4	4	4	4	4
5-moderately disruptive	5	5	5	5	5
6-	6	6	6	6	6
7-slightly disruptive	7	7	7	7	7
8-	8	8	8	8	8
9-not disruptive at all	9	9	9	9	9

V. PATTERNS OF SOCIALIZATION

A. INITIATES CONTACT WITH OTHER PATIENTS

⑰

1-never	1	1	1	1	1
2-	2	2	2	2	2
3-seldom	3	3	3	3	3
4-	4	4	4	4	4
5-with moderate frequency	5	5	5	5	5
6-	6	6	6	6	6
7-frequently	7	7	7	7	7
8-	8	8	8	8	8
9-almost always	9	9	9	9	9

	Week				
	1	2	3	4	5
B. OTHERS INITIATE CONTACT WITH PATIENT					
1-never	1	1	1	1	1
2- ⑱	2	2	2	2	2
3-seldom	3	3	3	3	3
4-	4	4	4	4	4
5-with moderate frequency	5	5	5	5	5
6-	6	6	6	6	6
7-frequently	7	7	7	7	7
8-	8	8	8	8	8
9-almost always	9	9	9	9	9
C. TIME SPENT SOCIALIZING WITH OTHER PATIENTS					
1-none	1	1	1	1	1
2- ⑲	2	2	2	2	2
3-a slight amount	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount	5	5	5	5	5
6-	6	6	6	6	6
7-quite a bit	7	7	7	7	7
8-	8	8	8	8	8
9-a very large amount	9	9	9	9	9
D. LIKED BY OTHER PATIENTS					
1-not at all	1	1	1	1	1
2-	2	2	2	2	2
3-a slight amount ⑳	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount	5	5	5	5	5
6-	6	6	6	6	6
7-quite a bit	7	7	7	7	7
8-	8	8	8	8	8
9-a very great deal	9	9	9	9	9
E. ISOLATED FROM OTHER PATIENTS					
1-extremely isolated	1	1	1	1	1
2- ㉑	2	2	2	2	2
3-quite isolated	3	3	3	3	3
4-	4	4	4	4	4
5-moderately isolated	5	5	5	5	5
6-	6	6	6	6	6
7-slightly isolated	7	7	7	7	7
8-	8	8	8	8	8
9-not isolated at all	9	9	9	9	9

	Week				
	1	2	3	4	5
VI. VISITING (IF VISITED) DIFFICULTIES WITH FAMILY DURING VISIT					
1-a very great deal	1	1	1	1	1
2-	2	2	2	2	2
3-quite a bit ㉒	3	3	3	3	3
4-	4	4	4	4	4
5-a moderate amount	5	5	5	5	5
6-	6	6	6	6	6
7-a slight amount	7	7	7	7	7
8-	8	8	8	8	8
9-none	9	9	9	9	9
VII. UNUSUAL BEHAVIOR					
A. AGGRESSIVE BEHAVIOR					
1-carried it out	1	1	1	1	1
2-made abortive attempt	2	2	2	2	2
3-talked about it	3	3	3	3	3
4-subtly implied	4	4	4	4	4
5-absent	5	5	5	5	5
B. ELOPEMENT					
1-carried it out	1	1	1	1	1
2-made abortive attempt	2	2	2	2	2
3-talked about it	3	3	3	3	3
4-subtly implied	4	4	4	4	4
5-absent	5	5	5	5	5
C. SUICIDE					
1-carried it out	1	1	1	1	1
2-made abortive attempt	2	2	2	2	2
3-talked about it	3	3	3	3	3
4-subtly implied	4	4	4	4	4
5-absent	5	5	5	5	5

CARD I

Note: (borderline
(borderline schizophrenia = schizophrenia
(borderline psychotic

Variable No. disregard)	Columns	Explanation of Variables	
1	1	1 = schizophrenic (admission or final diagnosis) 0 = not mentioned as schizophrenic	
2	2	1 = depressive (any mention of depression in admission or final diagnosis) 0 = no mention of the word	
3	3	1 = organic features (any organic non-medical diagnosis, e.g., epilepsy, retardation--unless specifically ruled out during hospitalization) 0 = none	
4	4	2 = schizophrenia, but no depression 1 = schizophrenia and depression, or neither 0 = depression, no schizophrenia	
5	5 & 6	age in years (2 digits)	
6	7	number of previous hospitalizations	) from psychiatrist's) initial interview,) and if patient is) confused, use) parents' question-) naire as final) criteria
7	8	number of previous psychiatrists	
8	9	duration of previous outpatient psychotherapy 0 = 0 months 1 = less than 6 months 2 = 6 months to 1 year 3 = more than 1 yr	
9	10 & 11	WAIS information score (2 digits)--score used in chart, e.g., 14 or 17, etc.--if only range is circled, use middle of range; if no brief test given, but full IQ is derived from full WAIS, see Marty.	
10	12 & 13	years education completed (in years) (2 digits)	
11	14	parent closest to (from psychiatrist's initial interview) 0 = mother 1 = neither, both, or other 2 = father	
12	15	felt this way before (from initial interview) 1 = yes 0 = no	

Variable (disregard)	Columns	Explanation of Variables
13	16	family boss (from initial interview) 0 = mother 1 = neither, both, or other 2 = father
	Note:	for all scores--if patient is discharged before second Q sort, use last week in hospital
14 & 15	17-20	P1, P2 (4 digits) psychiatrist's rating on overall evaluation (I)--summed horizontally over all 4 lateral columns, or prorated if less than 4 present. 17 & 18 during week first Q sort given to patient 19 & 20 during week second Q sort given to patient
16 & 17	21-24	P3, P4 (4 digits) depression--category 13, summed over all 4 lateral columns and prorated if necessary 21 & 22 during week of first Q sort 23 & 24 during week of second Q sort
18 & 19	25-28	P5, P6 functional psychopathology--adding together and summing overall all 4 lateral columns, prorating if necessary, using columns 1, 2, 3, 8, 21-25; if number is greater than 99, then use 99. 25 & 26 week of first Q sort 27 & 28 week of second Q sort
20 & 21	29-32	P7, P8 acting out behavior--sum of 5, 6, 9 & 10, score as above
22 & 23	33-36	P9, P10 hostility--sum of 10 & 11, same as above
24 & 25	37-40	P11, P12 complex depression score--sum of 13, 15 & 16, and subtracting sum of 14 & 17, same as above; a score lower than -9, counts as -9
26 & 27	41-44	P13, P14 somatic features, sum of 4, 15, 17, 26 & 27, same as above
28 & 29	45-48	P15, P16 anxiety--use II 1, same as above

CARD II

Columns	Variable No.	Explanation of Variables
1-4	R1, R2	recreational therapist's social participation, variables 7, 8, 11, 14, 19, 21--sum these 6 variables for weeks

Columns	Variable	Explanation of Variables
		of first and second Q sorts 1 & 2 = week of first Q sort 3 & 4 = week of second Q sort
5-8	R3, R4	leadership--sums of 9, 10, 11 & 14, same as above
9-12	R5, R6	competence--sum of 5, 6 & 7, same as above
13	R7	self responsibility--variable 5, first sort only
14 & 15	N1	responsibility--use variable I J, at first time period, sum of week of first Q sort (week includes Monday to Sunday of a week)--prorate if any items are missing and round out to nearest whole point, e.g., if 5 of 7 days are scored, add them up and multiply by 7/5.
16-19	N2, N3	liked by others--composed of sum of III E and III F, for entire week, prorate if necessary
20-23	N4, N5	psychopathology--add I C, H, & III A, K, L--prorate if necessary--add for entire week and subtract 100 from final score, a number smaller than -9 is scored as -9
24-27	N6 & N7	sociability--add I D, F, III B, C, D, G, prorate and subtract 100 and treat as above
28-31	N8 & N9	depression--composed of I G, H, & M and III M, prorate and subtract 50
32		weeks between second Q sort and discharge, and divide by 2--largest number you can score is 9 and smallest number is 0; if discharged after 1 week = 1, if discharged after 3 weeks = 2, etc.--round off to high number
33 & 34	FA 1, FA 2	taken separately--family variables (from sheets given to resident and social worker by Carrie)--if both are available take average of the 2--family strong man and identification 33 = FA 1 on discharge scale 34 = FA 2 on discharge scale count zeros as having been left blank
35-38	FC 1, FC 2	taken separately at time of second Q sort--scales C1 and C2 at time of second Q sort--if both resident and social worker scores are available, add them; if only one is available, double it
39-42	FA 3, FA 4	taken separately at time of second Q sort--add both social worker's and resident's--double if necessary

Columns	Variable	Explanation of Variables
3-46	FB 3, FB 4	at time of second Q sort, same as above--add resident's and social worker's, or double if necessary
7-50	FB 6, FB 7	at time of second Q sort, add social worker's and resident's--treat same as above
78	social class	use Hollingshead and Redlich classification for occupation alone--roughly, 1 = professional, 2 = semi-professional, small business, 3 = small managerial and skilled labor, 4 = anything else, 5 = unemployed --for students use parents--see Hollingshead and Redlich
79	R8	(liked by others) add recreational therapist's scales 18 and 20 and divide by 2.

Q SORT PROJECT

ADDITIONAL NOTES FOR COLLECTION OF DATA FROM CHARTS

CARD I

On first six lines of sheet, write out full admission diagnosis and full discharge diagnosis.

For parent closest to (Column 14, Variable 11) -- the psychiatrist's Initial Interview sometimes collects information on 2 time periods ("then" and "now"). If a disparity is present, note both "then" and "now" on a separate sheet and we'll assess it later.

CARD II

EXTRA INFORMATION TO COLLECT. This information should be circled, since it will not be used now, but will be used later.

Columns 13-15	Also collect and circle the same information at the time of the second Q Sort (Circle R7 for Column 13; and circle N1 for Columns 14 & 15)
Columns 39-42	Also collect and circle the same information collected at the time of the first Q Sort
Columns 47-50	Also collect and circle the same information collected at the time of the first Q Sort

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